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THE PSYCHIATRIC QUARTERLY SUPPLEMENT

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THE PHENOMENON OF RESISTANCE TO CHANGE IN A LARGE PSYCHIATRIC INSTITUTION*

BY TOARU ISHIYAMA, Ph.D., AND WILLIAM L. GROVER, M.D.

INTRODUCTION

One of the greatest obstacles in attempting to treat psychotic patients in a large mental hospital is the overwhelmingly foreboding atmosphere of the custodial orientation so prevalent in many of those hospitals. This custodial orientation, while historically a development of what was believed to be the need to protect the community from the mental patient, has been maintained by many factors. The two greatest contributors to the custodial orientation have been the pattern of psychiatric ideology which has determined the methods and techniques of patient care, and the sheer bigness of most mental institutions. This pattern of psychiatric ideology has been referred to as the psychotherapeutic orientation.** This orientation implies that the only real process of treatment occurs in the one-to-one relationship between a patient and a therapist, and that the hospital environment serves merely as a benign envelope within which therapy takes place. The assumption of this orientation almost necessarily relegates nontherapy personnel to custodial roles.

The authors suggest that a sociotherapeutic orientation, as opposed to the psychotherapeutic orientation, would go far toward reducing the custodial atmosphere of the large mental hospital. The sociotherapeutic orientation views as potentially therapeutic not only the formal treatment programs and the hospital personnel but also the total social structure of the hospital. More specifically, this orientation does not localize the curative agent in one person or group of persons. Every aspect of the hospital life is considered to be potentially therapeutic. Consequently, nontherapy personnel, as well as therapy personnel, can actively further the rehabilitation of the patient.†

The sheer bigness of most mental institutions is the second factor which contributes to the maintenance of the custodial atmos-

*Cleveland State Hospital, Cleveland, Ohio.

**Sharaf, Myron R., and Levinson, Daniel J.: Patterns of ideology and role definition among psychiatric residents. In: *The Patient and the Mental Hospital*. Milton Greenblatt, Daniel J. Levinson and Richard H. Williams, editors. Free Press, Glencoe, Ill. 1957.

†Op. cit.

phere. With bigness, comes emphasis on specialization, departmentalization, complex channels of communication, hierarchy of power, and all the other phenomena which make communication and co-ordination difficult. While these phenomena are not necessarily bad, they often produce feelings of isolation, of infinitesimal contribution, and of an overvaluation of status and power on the part of persons within the structure. To counteract these feelings, support is obtained through identification with one's department, deprecation of the efforts of "other-groups," and attempts to maximize one's power over others and to minimize one's power of being influenced by others. Overidentification with one's department or deprecation of other-groups is often associated with an unwillingness to communicate or to work co-operatively with others. The attempt to maximize power and to minimize one's own ability to be influenced may be manifested in stubborn adherence to one's views or, negatively, in the shirking of duties and the passing or avoiding of responsibilities. All these phenomena contribute to the maintenance of the status quo.

This paper is a report of the attempt to reorganize a large mental hospital, Cleveland (Ohio) State Hospital, along the lines of small, well co-ordinated and functionally autonomous units—as a method of decreasing the custodial orientation and increasing therapy potential—and of the consequent intense resistance to change engendered by the attempt.

THE SITUATION OF CHANGE

The attempt to engineer the proposed change involved initially a decision as to whether it was desirable for the change to be gradual or sudden, piecemeal or total. While there are many advantages accruing to a sudden, total reorganization, it was decided that a gradual and piecemeal process of change should be instituted. The crucial factor in this decision was the fact that the personnel to staff all the units that would be created by a total reorganization was not available. The reality of understaffing meant either a concentration of effort in a few areas, or spreading the ranks thin over a wide area. Since the goal of reorganization was two-fold, the reduction of bigness and the institution of a socio-therapeutic orientation by a team approach, the lack of necessary staff members would negate the second aspect of the goal. Consequently, it was decided to establish a demonstration project,

wherein the sociotherapeutic approach could be instituted in a relatively manageable unit.

Several objectives were implicit in the establishing of the project. First, it was to demonstrate that a sociotherapeutic approach could be instituted, and that such an approach would benefit patients and staff in terms of both immediate and long-range goals. If this were to be demonstrated, the project would set an example to which the whole staff could aspire. It has been observed that when attendants see wards other than theirs receiving things that their patients do not have, they begin to demand the same consideration for their patients. This aspect of competitiveness among the personnel can be utilized to generate greater personal involvement and a general improvement in conditions.

Second, the project was to demonstrate, not only that great improvements could be made by merely increasing efficiency and coordination and by instituting a rational program wherein everyone could make a very definite and important contribution, but that all this could be done without any substantial increase in personnel or in materiel.

There were several factors that had to be considered in setting up the project. Since it was to be a demonstration unit, it was felt that a degree of geographical separation from the rest of the hospital was essential. Second, selection of patients was initially important, in order not to doom the project from the start. However, after the initial population, the unit would take its proportionate and random share of admissions.

To put the project into motion required transfers of approximately 700 patients and numerous equipment. While only 220 patients were to be involved in the project, the requirement of special facilities for certain patients, and the fact that none of the wards was equipped completely and adequately to take any and all kinds of patients made necessary a complex series of transfers, and the recomposition of practically every female ward.

After several months of discussion and planning, the authors met with the chiefs of all of the departments that would be involved, nursing, maintenance, housekeeping, et cetera, to elaborate a plan of execution. In the meantime, most of the professional departments—social service, occupational therapy, and recreational therapy—had been informed about the plans to create a project unit.

The authors had assumed that the project would be in full operation in approximately four months, that the necessary patient and equipment transfers would have been completed and that the project team would be in a position to carry out an organized treatment program. This assumption had not adequately anticipated the resistance that eventually arose.

THE PHENOMENON OF RESISTANCE

The transfer of almost 700 patients, their belongings and a great deal of equipment naturally placed a tremendous load on the nursing and maintenance departments. Consequently initial resistance would be expected to come from those departments. It soon became apparent, however, that the resistance was not wholly a function of the extra work that the project did or would entail. Staff members who were not yet directly concerned or involved with the project began to be as much in opposition, if not more so, than either the nursing or maintenance staffs. Overt protests, complaints, criticisms, and hostile remarks were directed against the authors, who were early identified as the instigators of the project. The attitude that, "They don't know what they are doing," or, "This kind of thing has been done before and it's never worked," began to be expressed openly, though never directly to the authors. The fact that the mass transfers were upsetting the patients was used as proof that all of "the moving and fussing" was the product of sadistic, heartless, stupid, and ignorant thinking.

While the nuisance value of these overt expressions of resistance was usually no more than fleeting, they were portents of more critical things to come. First, they led to a decrease in morale and enthusiasm among some of the project-team members. This particularly applied to the attendants assigned to the project team, since they were not committed to the project philosophy to the same degree as the professional members, nor did they have the information to refute criticisms. Second, the overt expressions encouraged and stimulated covert, but more effective, expressions of resistance and dissatisfaction. Absenteeism increased, the usual reason given being "too much work for nothing." There occurred an almost deliberate inactivity; the rationalization being, "We're busy," or "We don't have the material," or "Nobody told me about this." There was an unreasonable and inappropriate reverting to the formal structure, "You have to go through channels," or

"Nothing can be moved, replaced, or changed without my order." Seduction of power figures in the administrative hierarchy was attempted. For various reasons, certain individuals already had grievances against the administration. These individuals could then be easily recruited as more voices to be leveled against the administration's "pet project."

In the face of increasing resistance, the progress of the project plans became excruciatingly slow. It became imperative that remedial measures be taken. There were two paths of action open. The first was to level the total force of the administration authority against the resisters. While this course was relatively easy and immediately accomplishable, the consequence of a show of power might be very negative. The basic problems, of which the resistance was merely a symptom, would remain. Second, forced co-operation could be sustained only as long as pressure could be sustained. Third, forced co-operation would tend to defeat the goal of increasing upward communication.

The second path of action was to analyze the dynamics of the total situation, isolate the problems, and then bring about appropriate remedial measures. This was the course taken.

The analysis of the situation revealed three basic factors as the underlying elements of the resistance. All the elements, however, were not necessarily existent in every individual who resisted. First, the institution of the process of change had aroused rather basic feelings of insecurity. Any change in the structure of the hospital was seen as a threat to established modes of operation. While most staff personnel had not achieved the most satisfactory positions they could hope for, at least they had achieved a reasonably comfortable equilibrium in their status strivings. They knew what was expected of them, how much they had to do and how much they could get away with. Their positions in the authority hierarchy were relatively well defined and stable. While staff-staff interactions might still present some problems, the modes of staff-patient and patient-patient interactions were defined rather clearly and in a generally acceptable manner. The demonstration project proposed new modes of interpersonal interactions and was thus perceived as a disturbing intrusion in the situation of calm, placidity and stability.

The perception of the demonstration project as a disturbing element was seen not only in terms of what was anticipated, but

also in terms of the present authority interactions. The most frequent manifestation of the latter was the complaint, "I was not consulted." Not being consulted became the basis for passivity, at best, or active blocking of the project.

Another threat to security was seen as being inherent in the new project. If the demonstration project could accomplish one of its goals, i.e., the provision of better treatment with consequent increase in the number of improved patients, this might be taken as an indication of the personal inadequacies of many of the staff members. The complaint, "They're taking all of our good patients," was probably partly related to the fear that the project might be too successful.

For some, the fear that the project might be too successful was mixed with envy. The possibility that someone else might enjoy the fruits of success while they were faced with the realization of inadequacy became the basis for the depreciation of the threatening project. The feeling of being left out was then one of the underlying factors in the expression of anxiety and hostility.

The second element in the resistance was generalized lethargy. The custodial atmosphere tends to foster a do-as-little-as-possible, keep-things-quiet attitude. This attitude, in turn, tends to serve as a polar force in attracting and holding individuals who are inclined to be lethargic. Consequently, any demand for greater activity, greater initiative, and greater involvement is met with an institutionally-organized resistance.

The third element in the resistance could be categorized as a general lack of information as to the goals and purposes of the project. This category also includes theoretical disagreement with the formulations involved in the project, as well as a genuine conviction of the invalidity of the techniques and methods proposed by those formulations. Although the professional staff had been relatively well informed about the project, the majority of the non-professional staff knew only that patients were being shifted around and that the population of one of the cottages was apparently being recomposed. This lack of information led to, or aggravated, feelings of insecurity. A large part of the resistance was a function of the lack of information, greatly exaggerated by the elements of insecurity and generalized lethargy. It was obvious that the indolent could not, or would not, change overnight. On the other hand, it was just as obvious that the lack of information

could be immediately rectified, and that measures could be taken to offset the security problems.

THE AMELIORATION OF RESISTANCE

Representatives of the project, therefore, requested permission to attend regular meetings of each hospital department in order to explain the rationale and purposes of the project. In conjunction with the formal meetings, it was made a point to contact informally as many staff members as possible, as frequently as possible, on an individual basis. It was important, at this point, that the project representatives make the initial moves, rather than call in individuals or groups for conferences. This procedure, it was felt, would avoid the authoritarian element involved in *calling* a conference and would tend to prevent any increase in status anxieties.

The meetings and contacts were structured in terms of three aspects. First, a straightforward explanation of the rationale and purposes of the project was given. This explanation was presented with the explicit assumption that the majority of the staff was interested in helping patients and in increasing the efficiency of hospital functioning. The fact that this assumption was made explicit served to disarm many staff members of their hostility immediately. The explanations were designed to inform the uninformed and to bring about neutrality, at least by those who were in theoretical disagreement with the rationale of the project.

Second, the meetings were designed to permit the venting of hostility by way of complaints and criticisms. Hostility based on misinformation was immediately alleviated by the informative nature of the meetings. Hostility based on actual or perceived slights was shorn somewhat of its venom by a matter-of-fact admission of fault by the project representatives and a promise of more consideration in the future. Displaced hostility, that is, hostility toward the project that was actually aimed at the administration, was met by careful, gentle and repeated attempts to point out the fact of displacement.

Third, the meetings were aimed to alleviate the security problems. Recognition of the efforts and general contributions made and of the handicaps and frustrations faced by all of the staff members was expressed. It was pointed out that the project was not meant to accuse anyone implicitly of a lack of effort, but was

aimed at an eventual alleviation of the handicaps and frustrations. To encourage the feeling that the project was a hospital project rather than the sole property of the administration or of the project staff, it was pointed out that the project could not exist without the good will, co-operation and direct involvement of everyone in the hospital. That the project staff and the administration were not the only ones with ideas was readily admitted, and contribution of ideas was requested from everyone. Apologies were made for the fact that some people were not consulted, and assurances were given that this was an oversight rather than a slight. That the project staff was inexperienced in administrative matters and that, consequently, many errors would be made was admitted. Finally, that the goal of the project was to improve conditions without additional personnel or materiel was again re-emphasized.

The individual contacts were designed to establish positive interpersonal relationships between the project staff and the rest of the hospital staff. It has been noted that the informal structure of the hospital is as important, if not more important, than the formal structure in determining the nature of interpersonal interactions and that co-operation and aid may be elicited much more readily when the interactions are on a basis of personal friendship. Thus, a concerted effort was made by the project staff to become acquainted with as many of the hospital staff as possible. In this respect, it is interesting to note that one of the complaints of an attendant was that most doctors did not even say, "Good morning," to her when they met in the halls.

Various other measures were also instituted to alleviate the resistance. As a means of involving as many members of the staff as possible, and also to point out that the project was a total hospital project, a contest to re-name the project building was initiated. The response was gratifying. While some entries were hostilely tinted, such as "Grover's Folly," and "Ishiyama's Folly," most were in keeping with the purposes and goals of the project.

The project staff also sponsored several teas and coffee hours for all of the employees who were directly involved in the establishing of the project—plumbers, carpenters, painters, electricians, nursing personnel, et cetera.

These various remedial measures were immediately successful. Although the initial response in the meetings was an unbridled ex-

pression of hostility, this was quickly changed to a more sympathetic and co-operative attitude toward the project. Anxieties about the implications of the project were relatively quickly dispelled. The task of completing the initial phase—the transferring of patients and the readying of the building—proceeded smoothly. Many of the attendants, as well as patients, began to ask to be transferred to the project. Excuses of no time or no material diminished. Supposedly nonexistent equipment made its appearance. The project needs were given top priority; contribution of ideas and offers of help increased. In a matter of weeks, more was accomplished than had been accomplished during several previous months. The remedial measures were stamped as highly successful.

DISCUSSION AND CONCLUSIONS

The relative ease with which the resistance was dissipated indicated that the analysis upon which the remedial measures were based was accurate. The resistance was not a function of a deeply ingrained need to resist but rather of factors that were relatively amenable to influence if they were recognized, and appropriate measures taken.

The dynamics of this situation were comparable to that found by Coch and French* in their experiences in an industrial plant. The resistance to change proceeded from the perception of the administration as a hostile power field. The resisting group attempted to reduce the strength of the hostile power field relative to the strength of their own power field by presenting a fairly well-united front of resistance, getting allies by recruiting discontented power figures in the administration, by attacking in the form of aggressive complaints and criticisms, and by actively placing obstacles in the path of the project.

The perception of the administration as a hostile power field was a function of individual reactions to the frustrations and anxieties incurred by perceived threats to security feelings, feelings of being left out, possible implications of personal inadequacies, intensifications of awareness of the gap between status striven for and status actually achieved, the desire to avoid job strain, and ideological differences with administration policies. The rejection of administrative pressure resulted in a resistive force which, when

*Coch, L., and French, J. R. P.: Overcoming resistance to change. *Human Relations*, 1:512-532, 1948.

mobilized, had an inherent drive to maintain itself. When—under the conditions of participation in decisions affecting the project—the feelings of insecurity were diminished, the perception of the administration as a hostile power field changed. The administrative pressure was now accepted, and this acceptance of the induced force set up additional “own” forces in the same direction. Hence, there was a sudden increase in spontaneous offers of help, of contributions of ideas, and so on. With this break in the united front, the forces set up by ideological differences with administration policies and the desire to avoid job strain were dissipated. It is true that individuals with ideological differences were in a small minority and that if the situation had been such that the staff was more evenly split ideologically, this factor would have presented grave problems. It is also true that the level of job strain demanded by the project was only as high as would produce strain avoidance in the most lethargic of individuals. If the levels of job strain demanded had been substantially higher, this factor too would have presented imposing problems.

There are several conclusions that can be gleaned from these experiences. First, in any effort to institute change, insecurity feelings cannot be overstimulated. If the change is accompanied by an increase in feelings of insecurity, and if these feelings are not resolved, an alliance with the forces of strain-avoidance and certain group standards—whether ideological, or standards to restrict productions, or whatever else—can be anticipated. Under such conditions, any change forced through by administrative authority is likely to be merely a change on paper, and to serve only to create more hostility, anxiety and resistance.

Second, if change is desired, this change must be induced through the informal structure of the institution, as well as at the level of the formal structure. The writers' experience has been that changes were most easily induced in an individual with whom they were on a personal and friendly basis. In such individuals, demands are not perceived as pressure, and no feelings of insecurity are aroused.

Third, most individuals who work in a mental hospital are basically interested in, and willing to help, patients. This positive force, if stimulated, can be utilized to bring about any desirable change. For example, when the purposes and goals of the project were explained to the nursing personnel at a meeting, the attendants

on the male services requested that a similar project be started for the male patients. This request served as a positive, competitive force to stimulate increased involvement on the part of the attendants on the female services.

Finally, it is the writers' conclusion that most ills in our institutions are not just the function of individual ills but also a function of institutional ills. It then behooves us to attempt to ameliorate those institutional ills whenever possible. It is proposed that a reorganization of the institution, as proposed in the introduction of this paper, might be useful in such an endeavor.

SUMMARY

This paper discusses the process of reorganization which occurred in a large state psychiatric hospital, analyzes the resistance to the reorganization, and relates the means utilized to ameliorate the resistance. The factors underlying the resistance were status threats to staff, the desire to avoid job strain, and ideological differences with administrative policies. The resistance was manifested in the attempt to reduce the strength of the administration by presenting a united front, getting allies by recruiting discontented power figures in the administration, by attacking in the form of hostile criticisms, and by actively placing obstacles in the path of the reorganization.

In an effort to decrease the strength of the resistance, a program designed to inform the uninformed, to allay the anxieties of staff members, and to encourage an involvement in the reorganization process was carried out. The program was immediately successful.

The following conclusions were gleaned from the analysis. (1) In any effort to institute change, insecurity feelings cannot be overstimulated. (2) Changes must be induced through the informal structure, as well as at the level of the formal structure. (3) Most individuals who work in a mental hospital are basically interested in, and willing to help, patients. (4) Most ills in a state hospital are not just the function of individual ills but also a function of institutional ills.

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THE PSYCHIATRIC NURSE AS A WARD THERAPIST*

BY KAREL PLANANSKY, M.D., Ph.D., AND ROY JOHNSTON, Ph.D.

The spirit, as well as the practice of treatment and of the rehabilitation program, in the present-day mental hospital reflects the transition from custodial care to what is currently visualized as a therapeutic community. Total patient care has been split into administrative compartments in which the therapeutic and rehabilitative tasks are carried out with different tools and attain different degrees of accomplishment. In this process, the ward as a basic unit of a therapeutic community loses its identity, and the natural role of the ward nurse, that of a therapist, possessing specialized tools, and in constant contact with patients, has been neglected.

Currently the ward nurse does primarily administrative work. Most of her time is spent at her desk, recording progress reports in detail, and writing treatment outlines on patients whom she sees only when distributing medicines, and with whose behavior she is acquainted mainly from aides' reports. Since most of the nurse's time and energy are absorbed by secretarial work, she can function as a psychiatrist's associate only secondarily. She rarely meets her patients in a therapeutic role.

The pressure of patient numbers and the increased load of mechanical administrative tasks are not the only reasons for the preponderance of nontherapeutic tasks in the nurse's working day. The nurse's own concept of her function very likely reinforces the trend toward the desk-type of job. It seems that the current model for the career nurse requires that she strive for supervisory activities which guarantee that she remains physically distant from patients.^{1,2}

Moreover, the main burden of rehabilitative care has been shifted to auxiliary services, since these services can care for large groups of patients with only a few qualified employees, and can neatly organize and schedule their many activities. Thus, precisely those patients who are fit for rehabilitation treatment on the ward are sent elsewhere to receive treatment, and to receive it from persons other than their nurses.

The structure of the rehabilitative facilities in a contemporary mental hospital, geared to serve the largest possible numbers, is

*From the United States Veterans Administration Hospital, Canandaigua, N. Y.

not determined solely by economy and centralizing trends. It reflects also the concept of hospital treatment connected with the term "total push."^{3,4} A vague belief still prevails that the way to cure schizophrenics is to force them to go cheerfully through activities of our own choosing around an eight-hour-a-day schedule. This concept of constant activity for patients ignores the essential feature of schizophrenic illness, that is, its seemingly autonomous course, apparently independent of any variables that can be manipulated. Daily experience certainly shows that a schizophrenic patient cannot be "pushed" into health. A forceful therapeutic endeavor may evoke in him still more uncertainty or resentment, rather than achieve a remission. Instead of forcing patients through planned "intensive" therapy programs, we should wait attentively and sympathetically with the patient for the time when he needs us, and is amenable to our reassurance, suggestion, and guidance. In this empirical approach, the patient's illness determines the mode and timing of treatment. It is the patient himself who accepts our help and accepts it only when his illness permits. Organized rehabilitation programs undoubtedly help some patients to leave the hospital, not because of therapeutic overactivity, but because eventually the patient's condition allows him to take advantage of these programs.

The typical area which cannot be reached by the scheduled, large-scale operations concerns the patient's intimate personal experiences and worries. A patient may go for months through good stimulation or remotivation programs and be daily exposed to resocialization efforts without ever noticing anyone around him. Yet the same patient may suddenly start talking to an aide or to the ward nurse, because she is *his* nurse, and because she was with him when he needed to confide in someone who was clearly on his side. The nature of the relationship between the patient and the significant figure on the ward, rather than the activity itself, is most significant in "resocialization."

Of course, group programs organized for the entire hospital population should not be abolished, nor can all patients have individual therapists or companions. In fact, many appear to benefit from group experience which prepares them for common life outside the hospital. But, although beneficial, mass programs must be supplemented by more personal and individual therapeutic opportunities supplied within the ward unit. Nurses and aides are

logically the people who should stay with patients all the time and share with them their home substitute, the ward. It is sensible then, to investigate whether nurses and aides can give this type of intimate, flexible, day-to-day treatment to their patients in a typical mental hospital.

The function of ward personnel, working in direct contact with patients in a wide variety of hospitals, has been observed in several recent studies.⁵⁻⁹ However, the penetrating account of the attitudes and apprehensions observed among the therapists, although relevant to the study of personnel-patient interactions, is of limited use as a source of hints for work in a large hospital.^{6,8} Therapeutic employment of the ward nurses and the revision of therapeutic goals and techniques have been dealt with in a few reports. Some of the observations made and opinions expressed challenge accustomed practices and stimulate curiosity.¹⁰⁻¹² Yet direct application to large public institutions of experiences gained in hospitals with high staffing patterns, selected patient populations, and different administrative policies is neither advisable nor practical. Any modification of nursing policy must first be tested experimentally under the usual conditions of hospital operation, and with regular ward personnel. The present report deals with such a trial of a new treatment plan on an acutely disturbed ward.

AIM OF THE PROJECT

The project was devised to determine if it is practical and advantageous for the nurse to work intimately with acutely disturbed patients, developing her own methods and programs independent of the scheduled rehabilitation and recreation activities. There are two main areas of interest. First, the therapeutic potential of the nurse is explored—on the assumption that her skill is not fully developed or utilized when she is greatly involved with administrative desk work. The second problem is to investigate the real value to patients of flexible, on-the-spot therapeutic ventures, these being distinguished from the usual structured rehabilitative activities.

The concept of the therapeutic ward milieu had already been applied in a variety of hospital settings.^{6-9,13} In these programs, special conditions had been felt necessary for testing such concepts. The most energetic and promising aides would be selected from the whole hospital to serve on the experimental ward. In

other studies, careful selection of nurses was made; and frequently such people had considerable preparatory formal training in psychiatric nursing techniques.¹⁴ Still other studies emphasized the value of the nurse-patient relationship when an abnormally high nurse-patient ratio existed,^{7, 13} i.e., 10 nurses for six patients.^{14, p. 402} The writers feel that the time has come to test whether the typical nurse employed in the typical mental hospital setting could bring about certain therapeutic gains with an average, unscreened group of disturbed patients.

PROJECT SETTING

The study was conducted in a building of the Canandaigua, N. Y., Veterans Administration Hospital which had already been developed into a therapeutic unit. Four wards of 33 patients each comprise this building of 132 patients, predominantly schizophrenic. It was formerly equipped as a maximum security building for suicidal and homicidal patients, to serve a hospital of 1,600 beds. About a year before the beginning of this study the patients were redistributed within the building on the bases of severity of illness and need for supervision. A disturbed patient, for example, is admitted to Ward A where most attention is needed and most therapeutic effort concentrated. As the patient improves, he advances to Ward B where he receives less supervision, and then to Wards C and D where he must assume some responsibility for his behavior and care. Independence is encouraged by granting ground privileges, together with a work assignment commensurate with the patient's state of health, talents, and personal interests. Ward D is an open ward, closed and supervised only at night. Wards A and B are located on the second floor and comprise one nursing unit with a head nurse in charge: Wards C and D are similarly organized on the first floor.

A number of patients were not present on the ward throughout the period of the study. Recent calculation of the turnover rate showed that in a seven-week period at least 20 patients were transferred to the building, either from other wards or as new admissions. Forty new patients were received in a typical three-month period.

It is important to state that members of the personnel of these wards had had some experience with a constant-companion type of therapy. A special rehabilitation program for a small group

of patients on "special observation" status was instituted experimentally some 12 months prior to the project described in this report. This group comprises five to 10 patients on Ward A who are considered acute suicidal risks. They are supervised constantly by a selected aide who acts as their companion and friend. Daily, four therapists, members of the physical medicine and rehabilitation division, spend several hours with these depressed men, for whom graded tasks and stimulating activities have been specially devised. The success of this program encouraged others of the personnel to undertake voluntary participation in the present study. Further, the rearrangement of the wards loosened the rigid structure of the patients' lives and thus time was available for nurses to conduct discussions in small groups, a very useful form of group psychotherapy without doctrine.

Operation of a ward team had been tried for over a year and found profitable. The usual daytime personnel consists of a psychiatrist, a clinical psychologist, a social service worker (half-time), four nurses, 10 to 14 aides (nursing assistants), and a specialist in recreation. The members of the team are expected to participate actively in regular discussions and to share in decisions.

PROJECT DESIGN

The test project was designed so that the typical or routine conditions of service were not changed or interrupted. A two-month control period preceded the study. The experimental variable introduced was the function and activity of the nurse, operating constantly with her patients on the ward. The effects of her presence were then measured by the patients' reactions and by observations of their behavior.

Intentionally, the nurses were left to their own resources, under only general instructions to interact with patients as they saw fit. This procedure was designed to be self-educational; and it was hoped that, for this reason, the changes resulting would be more lasting.

The patients' behavior was evaluated during both control and experimental periods by: (a) observations of the patients by personnel and (b) patient responses to psychological tests. Patients' reactions were evaluated by a ward behavior rating scale and by a tabulation of data reflecting levels of agitation or anxiety. For this purpose, hours of mechanical restraint were taken from regu-

lar hospital records. Numbers of altercations and doses of emergency medication were recorded especially for this project. The patients themselves expressed their feelings through the Cattell Anxiety Scale (IPAT, Self-Analysis Form, 1957) and a "Peer-Naming Technique."

A new behavior-rating scale was constructed, since it was felt that it would be advantageous to use an instrument designed specially to describe the behavior of acutely disturbed patients. It is a simple five-point, 11-item scale covering commonplace activities, such as eating, sleeping, attending rehabilitation programs, and degrees of sociability and friendliness.

The Cattell Anxiety Scale is a 40-item, self-reporting, paper and pencil test used to evaluate the levels of both overt and covert anxiety. The subjects check "yes," "no," or "uncertain" to statements presented in pamphlet form.

The ratings of ward behavior were made three times at two-month intervals: (a) in the middle of the control period, (b) in the middle of the experimental period, and (c) after the study was completed. These ratings were made by aides, who had been instructed in the proper use of the scale, but not otherwise influenced. The Cattell Anxiety Scale and the Peer-Naming Technique were administered to the entire patient group at about the same times that the ward ratings were made.

The nurses reported their experiences and reactions in detail, as well as their patients' behavior, in daily informal contacts and in regular weekly conferences with the investigators.

THE CONTROL PERIOD

During the two-month control period the ward routine was essentially unchanged. Two new nurses were assigned, simply to become acquainted with the ward. Typical daily activities for the nurse included administering medications, making rounds with the ward physician, writing notes on patients, and a multitude of administrative and supervisory duties. Actual contacts with patients were generally brief, occasionally longer when a patient needed attention for a medical illness or had been in an altercation. Routinely, the nurse observed her patients for signs of pathology or health and prepared daily reports for the ward physician.

THE EXPERIMENTAL PERIOD

In the experimental period, in addition to the duties just described, certain nurses were now expected to spend most of their time in the dayrooms. Three nurses were now available during the day shift for 66 patients on Wards A and B. Two of the three spent the entire day with patients, and were free of administrative duties.

Initially, the nurses formulated the new program in terms of activities. In the preparatory stage, the concept of an ordinary unstructured therapeutic contact with patients was apparently too abstract. It was easier to think of activities with definite names. The essence of the nurse's job, and thus her primary orientation, is to do things for patients. It remained for the nurses to discover for themselves that their mere presence was therapy as well.

Although the approach by way of activities was most natural and practical, it soon developed that a large part of the nurse's time was spent in exploring the patients' personal needs and problems. Discussion groups of various types were formed, most being unstructured, growing out of the demands of the patients for help and attention. This was the most conspicuous response of the patients in the initial phase. They revealed the same human problems, personal histories, self-doubts, etc., that have been recorded many times before in literature dealing with group psychotherapy.

The burdens of devising the actual programs and of making daily decisions were left to the nurses. Indeed, they developed, on their own, their personal nuances of therapeutic presence on the ward. In this manner, the self-imposed limits of individual performance could be assessed. To facilitate further the exploration of the optimal range of the nurses' therapeutic potentials, it was decided to draw upon their personal skills and inclinations. For instance, a nurse proficient in music organized a patient band on the ward. An aide who enjoyed gardening organized a group to plant flowers around the building, and worked with another group of patients in the hospital greenhouse. Nurses also joined patients in activities and games on the ward, like ping-pong, volleyball, badminton, darts, card-playing and group singing. A record-player was installed in the game room, a ward newspaper was organized, and the patients were encouraged to decorate the rooms for holiday parties. Nurses accompanied their patients to work

and recreation assignments, and they took small groups to the canteen and for walks in the park.

NURSES' PLANNING OF THE DAILY PROGRAMS

At the beginning the nurses felt that formal planning for a certain period was necessary—apparently from habit and in deference to the administrative spirit permeating all activities in a modern mental hospital. At the conclusion of the study, the nurses stated unanimously that the planning could be done only on the spot. "You could not plan for the whole week. You could do your planning every day in the morning but you knew you would have to make changes." The urge to plan for stated periods was abandoned gradually, as nurses began to understand that their task was not to emulate or duplicate the organized programs of other hospital divisions. More precisely, planning for the whole ward was done, not even from day-to-day, but from free-time to free-time. "We could not even meet every morning at the same time. When we had the time, we met with the aides and decided what to do." Furthermore, even small group programs had to be improvised daily. For instance, a system was tried by which a certain aide would have a definite group to care for throughout the week. This scheme did not work, since the aides had many other (routine) duties which could not be fully anticipated a week ahead; and on an aide's day off, a group would be without its leader. It was believed, however, that it would be advantageous to have the aides lead small groups if the personnel's schedule permitted this. Certain aides would be responsible for a swimming group, and others for a "messy" group, the latter consisting of patients in need of retraining in personal hygiene.

At first nurses worried about how to form groups for various programs, how to elicit patients' interest, and how to keep them together. Soon they found that groups usually developed almost spontaneously, without much effort on the nurse's part. "Patients flocked to me whenever I made an appearance. This did not upset my plans. On the contrary, it was easier that way to interest them." There are potential groups developing in a dayroom at all times, and their members remain dormant until someone gives them leadership or suggests activity. For example patients may be sitting around a table, doing nothing—with a pack of cards on the table. They will not play unless someone in authority takes

the lead. Later they may start playing without a leader. Nurses learned that even if patients did not act as a group, the mere fact that they happened to be together, for instance in the same corner or near a table, signified that they might be seeking each other's presence in at least a passive manner. The nurses found that one has to seek out such natural, apparently accidental, groups.

There were differences in the type of activity the nurse had to anticipate between Ward A and the other wards in the building. The nurse working with severely agitated patients spends more time in organizing structured activities and participating in them, than in talks with patients, since disturbed patients are not accessible to conversation. "You have to wait until they are ready to talk, and then they often approach you themselves." Further, the time apportioned to activity or to conversation depends to a certain degree on the nurse's personality.

The patients themselves expressed a personal preference for improvised activities, as contrasted with scheduled ones. Nurses noted repeatedly that patients distinctly like to do something different or unexpected. For instance, they like trips to the canteen, when announced unexpectedly. Not rarely, patients themselves make suggestions. "A patient would say, 'I'm short of cigarettes, let's play bingo.' So we play bingo for cigarettes." At other times, the nurse feels it is best to offer a choice, for instance, swimming or canteen, and let the men decide. Most patients enjoy making such decisions.

AIDES' PART IN THE PROGRAM

Traditionally, the aide's role has been essentially a directive one; and, on a disturbed ward, the primary responsibility has been to maintain safety. Moreover, prior to this project, the aides concerned had been alone with patients practically all the time, and had had to make their own decisions about the routine handling of patients. Their function in the experimental program had not been defined before its onset, mainly because it was not clear what changes in their position would be necessary. This lack of clarification caused some apprehension in the first weeks—the aides apparently were not sure of the limits of their authority and initiative when a nurse was in the dayroom with them. They did not feel at ease with nurses around all the time. Three men

felt so uncomfortable with the program that they requested transfers to other buildings. Two of these three had had more than 15 years of service, and in view of past experiences with very disturbed patients, sincerely mistrusted the new plan. On the whole, as the project proceeded, the aides developed positive interest and accepted the idea that their positions were complementary to the nurses' roles as ward organizers and therapists.

The nurses admitted that they had now learned for the first time what the aides actually do on the dayrooms, what their relationship is to patients and to nurses, and how it feels to stay with patients eight hours a day. Significantly, nurses soon discovered that aides are closer to patients than the nurses themselves are. "I learned that patients considered the aides companions rather than keepers because they spent more time directly with them than we did; they played with them and talked with them as equals."

At the completion of the study, both groups came to the conclusion that nurses cannot fully substitute for aides, and vice versa, in spite of some overlapping in their functions. Patients too, see the function of the aide and that of the nurse as separate roles. In the patient's perception, the nurses' and aides' skills and authority are on different planes. It was concluded that when aides alone are in the dayroom, patients do not receive the full range of nursing service. The nurses were definite about the patients' preference for having a female nurse on the wards. The aides privately admitted they would have felt more at ease with a male nurse. Interestingly, both nurses and aides were reluctant to accept the suggestion of introducing female aides on such disturbed wards as these.

It was agreed that the nurse cannot simply assign aides to activity groups, and content herself with supervision. The nurse has to direct the aides personally and work closely with the patients herself. All nurses were convinced that this type of program could not be carried on without the aides' active co-operation. "The aides made helpful suggestions, they knew patients' wishes and moods." Often they showed interest by starting group activities without waiting for the nurse. When a nurse was removed from one ward (at the completion of the study) an aide was assigned on his own initiative to take care of the free-time activity of the

dayroom. This "free-time-man" functioned satisfactorily, but with less scope than the nurse until a nurse was again available.

It was soon discovered that a formal ward therapy program cannot operate a full eight hours each day. The aides need an hour and a half to two hours in the morning for routine ward work. A nurse would say of the aides, "First thing in the morning, you are not wanted on the ward; you would upset their system, and you are not welcome to bring up suggestions as to changes in the program because they must have the work done." One might raise the question whether it would be advantageous to relieve the aides of part of their housekeeping duties. On the whole, it was found that one has to be well acquainted with the aides' timetable and their way of doing things to insure that the improvised programs will run smoothly.

RESULTS

This was an empirical study. No formal hypotheses were tested regarding the question of the nurses' new role on the ward. The nurses themselves reported how they operated, how they accepted their new duties, and the effects they believed they had on patients. The effects on patients were determined to some extent by more formal, although rather simple, tests and statistical tabulations. The results may be summarized briefly.

Behavior Rating Scale. An examination of the behavior ratings revealed that no significant change had occurred. Since the aides were not involved in the planning of the program, and did not have access to their own previous ratings, it was concluded that their observations were free from the usual biases. Interestingly enough, the aides were pleased to report in spontaneous comments, improvement in many of their patients; and they voiced a desire to see the program continued.

Tabulated Data. Another appropriate method of assessment is the tabulation and comparison of emergency medications, restraints, and altercations between patients. Such measures are especially appropriate for, and are in wide use for, severely agitated patients—Wilmer¹⁵ made a tabulation of the use of sedatives in 1957, and Hadwen¹⁶ reported on changes in restraints as early as 1840. Of the four wards studied, the two most disturbed were selected. For example, during the control period, 131 individual doses of emergency medications (sodium amytal, paraldehyde)

were given, whereas 93 were administered during the experimental period. In the breakdown into day, afternoon, and night shifts, the only statistically significant reduction occurred during the afternoon (4 p.m. to 12 midnight) tour of duty. Perhaps this reduction in the evening reflects the beneficial effect of the daytime activities. (The difference was evaluated by χ^2 , $P=<0.02$. The total initial applications of physical restraints—sheet, camisole, cuffs and belt—were reduced from 165 to 124, $P=<0.02 >0.01$.) Similarly, the total hours of the restraints were reduced from 648 to 554, which is likewise a statistically significant reduction. One overtly homicidal patient with organic brain damage, present throughout the study, accounted for a large proportion of these restraint hours. The only increase among restraints occurred in the hours spent by patients with cuffs and belt, not with sheet or camisole. This significant increase was observed in the afternoon (4 to midnight) and night (midnight to 8 a.m.) tours of duty. A simple explanation probably is that a nurse was not physically present in the dayroom on these two shifts.

Altercations were classified and tabulated, as they occurred, into major (involving an injury or a scuffle requiring separation by personnel) and minor (no injury or scuffle). The number of major altercations was significantly reduced, while a significant increase in the number of minor altercations was observed. There was no change when the two categories were combined, totaled and compared. One may wonder whether this difference reflects actual changes in the intensity of altercations, or whether therapeutic enthusiasm spuriously reduced the major-altercation category.

Cattell Anxiety Scale. Of the 132 patients in the building, 93 were able to take the Cattell Anxiety Scale test at the beginning of the control period, and 111 at the end of the experimental period. The mean scores were considerably higher than those seen in normals, but there were no significant differences in the group-total scores of the three testing points. When the "core" group was tabulated separately, a minor reduction was noted with a χ^2 of 4.58 ($P=0.05$). The core group was composed of patients who remained on the wards throughout the entire study period.

It may be of interest to mention that patients with neurotic and character-disorder diagnoses, and psychotic patients well enough to leave the hospital, tended to produce the lower anxiety scores. The highest scores were obtained from acutely ill patients,

and from those who constantly sought attention by whining, complaining behavior. The sensitivity of the test is revealed in yet another manner: Average anxiety scores, taken at the beginning, were highest on the most disturbed wards and lowest on the open ward.

Peer-Naming Technique. After they had completed the anxiety test, the patients simply listed the names of everyone they knew in the building. This was the peer-naming technique used. An average of 11.4 names (median=7) was given prior to the experimental period and 14.9 names (median=12) at the end of the study. Since the distribution curves were markedly skewed, the median test was used, and the difference was found significant, with $P=<0.001$. The writers believe these results show that the patients became more aware of people around them. It is also possible that they were simply less inhibited in writing the names. It is unlikely that the increase reflected a practice effect, since (a) there was a sizable turnover of patients from one testing to another, and (b) the patients did not anticipate repeated testing, as shown by their surprise at the last two testings. In any event, the ward personnel observes that patients are involved with their own psychotic experiences and personal problems most of their time, and the brief group-testing sessions are a minute experience by comparison.

WHAT HAVE THE PATIENTS GAINED FROM THE PROJECT?

When asked for evidence that the experimental program was beneficial to the patients, the nurses first mentioned shortened communication between patient and doctor. Patients tell the nurse about their immediate troubles, inquire about their treatments, etc. Even when the patients are approached repeatedly by the ward physician or engaged in casual conversation during the daily rounds, some are still unable to present their wishes and complaints in such a direct approach. Many patients under such circumstances venture to address a nurse or a doctor only after much hesitation, and do so in a round-about manner. The nurses learned, however, that even men who appeared to be indifferent or contented, actually want very much to talk to the doctor, but their illnesses hold them back. The nurse who is constantly available, is finally approached as a mediator. Patients often seek from the nurse an authoritative explanation concerning their illness or

concerning hospital policies. Even when the doctor has discussed the problem repeatedly and thoroughly with him, the patient wants further elaboration or reassurance. Usually he turns to the aides, since they are members of the hospital personnel and are within easy reach. During such talks with patients, the nurses discover features of patients' illnesses, or circumstances of their family lives, that are unknown, both to the psychiatrist and the social service worker.

The second striking discovery in the nurses' opinion was the increase in conversation among patients and their apparent desire for contact with others. After a brief period of initial uncertainty and wondering, many patients talk freely and spontaneously to the nurses. More significant and more surprising to the personnel, the patients begin to talk to each other.

The ward personnel believe that the presence of a female nurse on the ward influences the patients' manners: They are neater, better groomed, and use less crude language. Resistance had been anticipated from certain patients who were notorious for their dislike of women. It was noted, that the most marked change occurred in these particular men. After a brief stage of evident tension, these patients not only accepted the nurses but enjoyed and demanded their attention for themselves.

The nurse gradually assumed the role of a female companion, of a confidante whom these tense and anxious men evidently needed. At the beginning, some unrefined advances were noted, but these soon ended. Then the patients merely wanted to talk to a woman who was willing to listen sympathetically. Some patients present the same complaints, troubles, and imaginary accusations daily. More often, they bring up practical problems in the hope of obtaining advice or help. Agitated, acutely-ill patients are often puzzled by the meaning of sex and feel threatened by women. Moreover, several patients on the most disturbed section are in homosexual panics. For these reasons, their responses to a female nurse are revealing. Probably, since a woman stays with them in a protecting role, they are able to discard some of their anxiety. However, in the few cases observed, the improved relationship with women on the ward has not been extended to the patients' responses to their wives or mothers, with whom they have had difficulty.

A nurse who appears in the dayroom only to distribute medications, to look for signs of physical illness, or to attend to behavioral emergencies, cannot be accepted as a confidante because she is not close enough to her patients. They do not know her well enough and do not have the feeling that she is "theirs" exclusively. Significantly, even patients whose mothers and wives visit regularly take the nurse into their confidence. Evidently, in her ward role, the female nurse cannot be replaced by any other category of hospital personnel, and she can fulfill this role only when she spends most of her time with the patients.

Finally, it is seen that a "gentler" climate is maintained in the dayroom since the nurse has been there. Certain attentions are given to patients when she is there which probably would be omitted if she were not around. Furthermore the length of a patient's stay in restraint is generally shorter, and although no relevant event can be cited as an example, it can be reasonably assumed that patients will not be mistreated through lack of skill when a female nurse is around. It is almost unfair to both patients and aides to be left without the nurse's professional guidance.

WHAT HAS THE NURSE GAINED?

Job satisfaction is given spontaneously and enthusiastically as the main gain from the program by all nurses and by several of the aides. The nurses report considerable satisfaction from observing directly how various treatments work: "You see behavioral changes that occur with various therapies, and you can watch the effects step by step. I can now report on treatments properly, and I feel more confident when making suggestions to the doctor as to further management of the case."

The nurses are happy over the discovery that they can accomplish more than they ever believed. They have become aware of the range of their technical skills through direct application, and the success in new therapeutic ventures gives them both professional and personal pride. This pride is exemplified by exclamatory statements such as: "You really work like a psychiatric nurse." "This was the first time I could practice what I have been taught in the course." Or, "My days go faster now, I just am more pleased with my work." It may be assumed that nurses enjoy having additional power over patients, derived from the wider range of thera-

peutic techniques. Statements like, "I have more influence on the patients now," certainly reveal an awareness of power.

Assignment to these very disturbed wards had been traditionally considered an exclusively male prerogative. In fact, the aides used to feel they had to protect the female nurse whenever she entered the dayroom. This study has shown conspicuously that the female nurse can approach even the most agitated patient without the customary protective squad. Male help is indispensable only when mechanical restraints are applied or when patients in altercations are separated. It is assumed that this study has been educational and has demonstrated to male personnel that muscular strength is not always necessary in dealing with the majority of disturbed patients.

Almost with an apology, the nurses mentioned that certain patients simply could not be reached. Of necessity, the most refractory cases of the entire hospital population are found on a very disturbed ward. For instance, the nurses failed to achieve any results with the patients showing severe character disorder, and with the severely regressed schizophrenics. The personnel learned that such men are apparently influenced neither by a direct masculine approach nor by female sympathy and nursing skill in such a short time as was covered by this study.

DISCUSSION AND CONCLUSIONS

This research has been designed as a study of nursing technique, and, therefore, one should examine how it affected both patients and nursing personnel.

The writers feel that the most obvious gains accrued to the personnel. Its members enjoyed participation in an exploratory venture, and they now have more confidence in their skills. The nurses had ample opportunity to test actively their plans and personal potential, which allowed them to redefine their own roles. The nursing assistants' concept of their own functions in co-operation with the ward nurse remained largely unclarified.

The appreciation of the need for constantly exploring new ways of treatment is of special significance at this time when the tranquilized, submissive patients could induce an illusion of final therapeutic achievement. The risk that we may be entering another static phase in treating long-term patients seems greater with tranquilizers than with therapies of the past because the effect

is unprecedented and the method a medical one. The nurse on a disturbed ward now wields a potent medical tool. Typically, the physician is often requested to increase the tranquilizing medication dose as an alternative measure to a mechanical restraint. At long last, the nurse can actually do what she has traditionally been doing, i.e., give medicine to patients. Thus with sure practical results obtained under gratifying circumstances, therapeutic goals might become blurred.

Only by staying with patients through all phases of their outbursts, have the nurses learned that restraint, whether mechanical or chemical, can be turned into a useful investment when applied as the first part of emergency treatment. Restraint should always be followed by further nonmedical treatment given by the nurse personally and on-the-spot. Further, when she organizes activity groups she learns to look for signs of alertness in withdrawn patients; alertness now being more desirable than bland placidity. Through their own trials and errors, nurses have discovered that with the distribution of pills their therapeutic opportunity only begins.

The flexibility of the experimental programs was appreciated by both personnel and patients. No matter how excellent and unobtrusive the rehabilitation program is when it is administered within a rigid "master schedule," patients are apt to perceive it as compulsory, as something like army details. In a typical reaction, a man said with visible distress when asked to explain why he refused to go to the scheduled program in the gymnasium, "but if everybody goes and I must go, I am not... I am not I, I am everybody." Another veteran exclaimed, "Why must everyone be forced to do what the group does—what are you people trying to prove?" And another man who was preparing for a trial visit home firmly argued that he felt he "lost a part of himself," when he was regimented into activities prescribed for the group. Such comments suggest the need for more tailor-made, on-the-spot, flexible activities to prevent further loss of the patient's identity. Even patients who do participate in scheduled rehabilitation programs should have an opportunity to do something in a small "private" group, perhaps in an improvised setting.

It would be both improper and impossible to separate activities from pure therapy. One cannot start the treatment of a schizophrenic in the hospital just by talking, one has to do something for

him and with him first. The very nature and course of the illness precludes the planning of formal psychotherapy only. It is not enough to encourage patients verbally to play ping-pong, or operate the record-player. The therapist must first call the patients to the table and hand out the ping-pong paddles, or choose a record and start playing himself. Later, patients will continue by themselves, and still later they approach the therapist with personal questions. Thus, it is good psychiatric practice to begin planning with activities when the intent is to conduct psychotherapy.

Significantly, all nurses and many aides have found considerable improvement in their patients, and enthusiastically report concrete instances. The writers are unable to assess exactly what changes have taken place. Very likely, the improvement—so necessary for the maintenance of the personnel's morale when unaccustomed programs are introduced—cannot be measured by the usual tools. It is worth noting that no change is shown in ward behavior-ratings, in spite of personnel accounts of individual improvements. The rating is done by aides, whose attitude is, on the whole, detached and is thus most desirable for this purpose. They have no theory to test; no postulate to confirm. The discrepancy between honest reporting of individual changes and evaluation by a structured scale, may suggest that in general, reports of improved ward behavior, regardless of the method used (anecdotal report or behavior scale), must be soberly examined in relation to the observer's attitudes.

In this experiment, it can be inferred that the aides merely recorded what they saw, namely, that the patients were as ill at the end of the study as they had been at the beginning, although the ward climate was more relaxed, there was less tension, and the personnel's attitude was more therapeutic. This observation is entirely in keeping with psychiatric experience: that the essential illness as seen in the behavior of a sizable portion of the schizophrenic population in our mental hospitals remains, on the average, unchanged. Furthermore, a small proportion of the patient population became worse during the time of the experiment. Since the personnel had invested so much time and energy in the project, it is understandable that they readily perceived successes. They were so accustomed to seeing therapeutic failures that slight improvements were, by contrast, easily

noticed. Apparently a large quantity of mature optimism is necessary to distill out small amounts of therapeutic gain.

It was reported that, on the average, patients talked to each other more at the end of the experimental period, and the writers would like to interpret this observation as an increase in social awareness. It might be objected, of course, that this resulted from habit formation, or simply reflected the general ease in the day-rooms. Certainly, it had been planned to bring patients together under pleasurable circumstances.

One must remember that group interaction and cohesion in itself, is not necessarily therapeutic. Occasionally, groups form spontaneously and interact, and the members plan activities which are detrimental to their own interest, if they are left without proper guidance. Patients have planned together to escape—and have done so successfully. Depressed patients congregate and discuss suicide. For example, one older man who was under special precautions was heard to remark to the other agitated men in a self-developed group: "You young fellows can still do it [suicide]; I'm too old." Such undesirable groups seem to elude persistent therapeutic efforts, and their leaders wield influence which amazes the therapists.

During this study, members of the personnel were enthusiastic about the spontaneous formation of recreation groups. These were transitory, fleeting groups, formed almost passively for the patients' own enjoyment. The writers have no conclusive evidence that such sociability generalizes to situations outside the hospital. Perhaps the question of whether gains from group experience in the hospital are extended to life outside the hospital is worthy of investigation. It is certainly easy to recall numerous patients successful in hospital group activities (sports, patient government, etc.) who were unable to fit into the most ordinary groups in everyday life.

It is readily seen that one nurse cannot be a companion and confidante to all patients in the dayroom, and thus the direct benefits have to be rationed out to a selected few at a time. Moreover, about one-third of the men on the most disturbed ward could not be reached. Yet, any type of companion-therapy or sharing-therapy somehow reaches many more individuals than those directly involved. There is evidence that all the patients noticed, and responded to, the nurse's presence on the ward. For instance,

one patient called the charge nurse the "medical nurse," and the ward nurse, who stayed with him, the "social nurse."

The freedom to choose programs and ways of approach to patients led the nurses to evaluate critically both the power and the limits of their techniques and personal influence. A nurse who has been working continually with patients in their own milieu, trying to find cues for her next move based on their moods, will be better prepared to absorb a disappointing relapse following a period of appropriate improvement. It is plain that nurses participating in this project acquired a more mature view of their own roles as well as of the goals and limitations of psychiatric therapy. This professional maturity helps to maintain the kind of balanced therapeutic ambition which is prerequisite for work with long-term psychotic patients.

In conclusion, the observations in the experiment have shown that scheduled rehabilitation programs should be complemented by ward-centered activities under the guidance of a nurse. The nurse should be constantly with a group of patients not larger than the dayroom unit, acting as their companion and confidante. The presence of a nurse in the dayroom of disturbed wards definitely secures a more therapeutic climate for patients.¹⁷ Assuming this role is, in itself, actual treatment, which offers the patient assistance as soon as his illness permits.

SUMMARY

On the assumption that the skill of the psychiatric nurse in a typical mental hospital is neither fully developed nor utilized, an investigation was undertaken to explore the therapeutic potential of a nurse working constantly and independently on the ward with very disturbed patients. Nurses were so assigned in an experimental project. In this manner, the real value to patients of flexible, on-the-spot therapeutic ventures was examined, as distinguished from the usual structured rehabilitative activities, designed for the whole hospital population. The therapeutic rationale, fortified by this program, is that the nurse must be physically present on the ward, so that she can observe her patients at first hand and be available to them. The patients are then more likely to approach their nurse for advice, and therapeutic measures can be introduced at the earliest opportunity.

The presence of a female nurse on the disturbed ward secured a more therapeutic climate for patients and resulted in decreased use of physical and chemical restraints. The nurses became aware of the range of their technical skill and discovered the personal power of a therapist who is in close contact with his patients. Furthermore, they acquired a more mature view of their own roles, as well as of the goals and limitations of psychiatric treatment.

The measurements of sickness, assessed by behavior ratings and an anxiety scale, showed no clear change with the new nursing technique, despite the personnel's enthusiastic accounts of the patients' improvement. Patients showed greater social awareness, as measured by a peer-naming technique. The greatest gains accrued to the personnel. The nurses found they derived more satisfaction from their work, and they enjoyed the opportunity to test their personal influence over patients.

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A MENTAL HEALTH SURVEY OF OLDER PEOPLE. III*

BY THE STAFF OF THE MENTAL HEALTH RESEARCH UNIT

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3.1 SOCIAL AND PERSONAL CHARACTERISTICS OF THE POPULATION

The study population is a population over 65 which is not in mental hospitals. The increasing rates at which older persons are going to mental hospitals have led to a wide variety of speculative explanations for the phenomenon. Many of the explanations advanced presume a certain picture of the life situations of elderly people. The data collected in this survey provide a rough picture of certain features of the life situations of an elderly urban population. The description of life situations offered in this section is provided as a small contribution to our knowledge of the life circumstances of elderly people in one segment of one American city in 1952. The wide variety of living circumstances should, at least, help to dispel some stereotyping formulations of the way in which the elderly live. Extrapolations of these findings to other populations, particularly with respect to the frequency of various characteristics, should not be attempted without careful consideration of the way this sample was drawn, the type of interview used to gather data, and the number of persons in the sample for whom data were not gathered.

The following picture is best seen as a description of the life circumstances of persons who were not in mental hospitals at the time of the survey.

3.1.01 Age and Sex Characteristics

The age distribution of this population over 65 shows a skew to the left. This presumably reflects the heavy toll which deaths take during this period of life. The population 75 and over is about half the size of the population 65-74 for both men and women. Table 3.1 shows the age distribution of this population. It may be compared with survivorship curves of larger populations.

The sex ratio (men to women) is 0.76 in persons aged 65-74 and is 0.85 for those over 75 (median age 78 years).

Table 3.1. Frequency Distributions of Social and Personal Characteristics of Interviewed Persons by Sex and Age (Sections 3.1.01-3.1.23)

Section number	Item	Number						Per cent					
		Men			Women			Men			Women		
		65 74	75 over	Total	65 74	75 over	Total	65 74	75 over	Total	65 74	75 over	Total
.01	Total number interviewed*	462	240	1,590	606	282	100.0	100.0	100.0	100.0	100.0	100.0	100.0
.02	Rating of housing:												
	(a) Very good	1	0	9	4	4	0.6	0.2	0.0	0.7	1.4	1.4	1.4
	(b) Good	22	10	87	28	27	5.5	4.8	4.1	4.6	9.6	9.6	9.6
	(c) Fair	212	87	688	277	112	43.3	45.9	36.1	45.7	39.9	39.9	39.9
	(d) Poor	183	106	652	260	103	41.0	39.6	44.2	42.9	36.5	36.5	36.5
	(e) Very poor	36	19	98	25	18	6.2	7.8	7.9	4.1	6.4	6.4	6.4
	Community institution	7	17	47	5	18	3.0	1.5	7.1	0.8	6.4	6.4	6.4
	Unknown	1	1	9	7	0	0.6	0.2	0.4	1.2	0.0	0.0	0.0
	Total of a, b and c	235	97	784	309	143	49.3	50.9	40.2	51.0	50.9	50.9	50.9
	Total of d and e	219	125	750	285	121	47.2	47.7	52.1	47.0	42.4	42.4	42.4
.03	No physical symptoms or restrictions on "mobility"	262	75	709	278	94	44.6	56.7	31.3	45.9	33.3	33.3	33.3
.04	Disorders of organs of communication:												
	Severe	7	6	41	15	13	2.6	1.5	2.5	2.5	4.6	4.6	4.6
	Moderate-mild	33	34	182	67	48	11.4	7.1	14.2	11.1	17.0	17.0	17.0
.05	Chronic or progressive disease:												
	Severe	39	30	183	76	38	11.5	8.4	12.5	12.5	13.5	13.5	13.5
	Moderate-mild	107	81	475	192	95	29.9	23.2	33.8	31.7	33.7	33.7	33.7
.06	Tremor	10	11	29	5	3	1.8	2.2	4.6	0.8	1.1	1.1	1.1
.07	Stroke	12	13	45	14	6	2.8	2.6	5.4	2.3	2.1	2.1	2.1
.08	Limited physical movement and limit on activity	90	91	423	140	102	26.6	19.5	37.9	23.1	36.2	36.2	36.2
	Physical status unknown	14	7	52	16	15	3.3	3.0	2.9	2.6	5.3	5.3	5.3

*Exclusive of two cases with unknown age.

Table 3.1. Frequency Distributions of Social and Personal Characteristics of Interviewed Persons by Sex and Age (Sections 3.1.01-3.1.23)
(Continued)

Section number	Item	Number				Per cent			
		Men		Women		Men		Women	
		65 to 74	75 over	65 to 74	75 over	65 to 74	75 over	65 to 74	75 over
		Total		Total		Total		Total	
.09 Household members:									
	Lives alone	236	41	29	103	63	14.8	8.9	12.1
	Lives in room	88	31	25	21	11	5.5	6.7	10.4
	Lives in community institution	47	7	17	5	18	3.0	1.5	7.1
	Lives alone with spouse	453	178	79	155	41	28.5	38.5	32.9
	Lives with spouse and children	227	107	30	79	11	14.3	23.2	12.5
	Lives with spouse and others, not children	52	26	2	21	3	3.3	5.6	0.8
	Lives without spouse, but with children	314	36	38	135	105	19.6	7.8	15.8
	Lives without spouse and children, but with others	163	33	19	84	27	10.3	7.1	7.9
	Household members unknown	10	3	1	3	3	0.8	0.6	0.4
.10 Type of dwelling unit:									
	Single private	517	155	71	199	92	32.5	33.5	29.5
	Flat or apartment	702	208	81	295	118	44.2	45.0	33.8
	Housing project	176	39	34	71	32	11.1	8.4	14.1
	Room	90	32	25	22	11	5.7	6.9	10.4
	Community institution	47	7	17	5	18	3.0	1.5	7.1
	Other	53	20	10	13	10	3.3	4.3	4.1
	Type unknown	5	1	2	1	1	0.3	0.2	0.8

Table 3.1. Frequency Distributions of Social and Personal Characteristics of Interviewed Persons by Sex and Age (Sections 3.1.01-3.1.23)
(Continued)

Section number	Item	Number						Per cent					
		Men			Women			Men			Women		
		65 to 74	75 to over	Total	65 to 74	75 to over	Total	65 to 74	75 to over	Total	65 to 74	75 to over	Total
.11	Time since last change of address:												
	Less than 5 years	479	142	75	185	77	30.1	30.7	31.3	30.5	30.5	27.3	
	5 to 9 years	256	71	40	108	37	16.1	15.4	16.6	17.8	17.8	13.2	
	10 to 19 years	273	91	27	104	51	17.2	19.7	11.2	17.2	17.2	18.1	
	20 or more years	529	149	81	203	96	33.3	32.3	33.6	33.5	33.5	34.2	
	Entered community institution with- in last 5 years	47	7	17	5	18	2.9	1.3	7.1	0.8	0.8	6.4	
.12	Unknown	6	2	0	1	3	0.4	0.4	0.0	0.2	0.2	1.1	
	Employment status:												
	Employed, full or part time	379	226	34	99	20	23.8	48.9	14.1	16.3	7.1	7.1	
	Housewife	575	0	0	373	202	36.2	—	—	61.6	71.6	71.6	
	Not employed	627	234	206	129	58	39.4	50.6	85.8	21.3	20.6	20.6	
	Unknown	9	2	0	5	2	0.6	0.4	—	0.8	0.7	0.7	
.13	Marital status:												
	Married	752	319	118	256	59	47.3	69.0	49.0	42.2	20.9	20.9	
	Widowed	639	74	88	276	201	40.2	16.0	36.7	45.5	71.3	71.3	
	Divorced or separated	77	25	17	30	5	4.8	5.4	7.1	5.0	1.8	1.8	
	Single	118	42	16	43	17	7.4	9.1	6.6	7.1	6.0	6.0	
	Unknown	4	2	1	1	0	0.3	0.4	0.4	0.4	0.2	—	

Table 3.1. Frequency Distributions of Social and Personal Characteristics of Interviewed Persons by Sex and Age (Sections 3.1.01-3.1.23)
(Continued)

Section number	Item	Number				Per cent			
		Men		Women		Men		Women	
		65 to 74	75 and over	65 to 74	75 and over	65 to 74	75 and over	65 to 74	75 and over
		Total		Total		Total		Total	
.14 Place of birth: Native-born—									
	Onondaga County	439	97	181	87	27.0	21.0	29.9	30.9
	New York State (outside Onondaga County)	438	122	168	79	26.9	26.4	27.7	28.0
	United States (outside New York State)	222	68	82	46	14.0	14.7	13.5	16.3
	Foreign-born	505	173	173	69	31.8	37.4	28.5	24.5
	Unknown	6	2	2	1	0.4	0.4	0.3	0.4
.15 Education completed:**									
	One year or more of high school ...	273	74	126	45	31.9	33.8	36.1	27.1
	Less than high school	484	124	192	92	56.5	56.6	55.0	55.7
	Unknown	100	21	31	29	11.7	9.6	8.9	17.5
.16 Self rating of health:									
	Good	654	247	231	94	41.1	53.5	34.0	33.5
	Moderately good	653	153	110	255	41.1	33.1	45.8	47.9
	Poor	232	49	35	106	42	10.6	14.5	14.9
	Unknown	51	13	14	11	3.2	2.8	5.4	3.9
.17 Desire to work:									
	Does not want to or does not feel able	455	161	159	91	44	34.9	66.3	15.6
	Wants to work because of the need for the money or activity	107	55	18	28	6	11.9	7.5	4.6
	Wants light or part time work	53	28	13	9	3	6.1	5.4	1.1
	Unknown and non-committal	975	218	50	478	229	47.2	20.8	78.9
						61.3			81.2

**Includes only those born in New York State.

Table 3.1. Frequency Distributions of Social and Personal Characteristics of Interviewed Persons by Sex and Age (Sections 3.1.01-3.1.23)
(Continued)

Section number	Item	Number						Per cent					
		Men			Women			Men			Women		
		65 to 74	75 and over	Total	65 to 74	75 and over	Total	65 to 74	75 and over	Total	65 to 74	75 and over	Total
.18	Satisfaction with income:												
	Satisfied	277	96	814	312	129	51.2	60.0	39.8	51.5	45.9	45.9	
	Less than satisfied	88	60	351	146	57	22.1	19.0	25.0	24.1	20.2	20.2	
	Completely dissatisfied	76	57	297	107	57	18.7	16.5	23.7	17.7	20.3	20.3	
.19	Loneliness:												
	High degree	22	19	118	53	24	7.4	4.8	7.9	8.7	8.5	8.5	
	Moderate degree	73	55	358	144	86	22.5	15.8	22.8	23.8	30.6	30.6	
	Low degree	337	133	1,002	378	154	63.0	72.9	55.2	62.4	54.8	54.8	
.20	Friends and social contacts:												
	Few or none	134	84	535	205	112	33.6	29.0	35.0	33.8	39.7	39.7	
	Some with or without limitations ..	306	139	985	387	153	61.9	66.2	57.9	63.9	54.3	54.3	
	Unknown	22	17	70	14	17	4.4	4.8	7.1	2.3	6.0	6.0	
.21	Activity in organizations:												
	Active	194	74	638	262	108	40.1	42.0	30.8	43.2	38.3	38.3	
	Not active	254	151	893	327	161	56.2	55.0	62.9	54.0	57.1	57.1	
	Unknown	14	15	59	17	13	3.7	3.0	6.3	2.8	4.6	4.6	
.22	Satisfaction with housing:												
	Satisfactory	344	160	1,103	411	188	69.4	74.5	66.7	67.8	66.7	66.7	
	Unsatisfactory in some respect	68	36	305	142	59	19.2	14.7	15.0	23.4	20.9	20.9	
	Unknown	50	44	182	53	35	11.4	10.8	18.3	8.7	12.4	12.4	

Table 3.1. Frequency Distributions of Social and Personal Characteristics of Interviewed Persons by Sex and Age (Sections 3.1.01-3.1.23)
(Concluded)

Section number	Item	Number						Per cent					
		Men			Women			Men			Women		
		65 to 74	75 over	Total	65 to 74	75 over	Total	65 to 74	75 over	Total	65 to 74	75 over	Total
23	Reported sources of income:†												
	Social security	150	93	452	171	38	28.4	32.5	38.8	28.2	28.2	13.5	
	Old age assistance	41	61	248	80	66	15.6	8.9	25.4	13.2	13.2	23.4	
	Relative or friends other than spouse	45	43	357	163	106	22.5	9.7	17.9	26.9	26.9	37.6	
	Savings, insurance, inheritance	41	39	197	78	39	12.4	8.9	16.3	12.9	12.9	13.8	
	Pension (including widows)	90	50	252	87	25	15.8	19.5	20.8	14.4	14.4	8.9	
	Current earnings (including income from real estate)	261	58	629	253	57	39.6	56.5	24.2	41.7	41.7	20.2	
	Rents rooms	17	9	94	50	18	5.9	3.7	3.8	8.3	8.3	6.4	
	Other (including compensation)	5	1	13	5	2	0.8	1.1	0.4	0.8	0.8	0.7	
	Lives with others and degree of independent support unclear	12	8	58	26	12	3.6	2.6	3.3	4.3	4.3	4.3	
	Not stated	14	10	62	17	21	3.9	3.0	4.2	2.8	2.8	7.4	

†Multiple sources tabulated separately. Sources of income of spouse tabulated for married persons.

In some respects, the life situations of the people in this population change with age or sex, in other respects there is remarkably little variation.

3.1.02 Quality of Housing

The bulk of this population lived in houses rated either "fair" or "poor." (See Section 1.2 for the way in which these ratings were made.) The quality of housing did not vary much in the two age groups, nor did the two sexes show large differences in this respect. (Table 3.1)

3.1.03 Physical Symptoms

The data on physical symptoms reported by the interviewers in Questions 12-21 were divided into three groups, rated severe, moderate and mild. (See Section 1.341.) They were also rated with respect to whether the data indicated limitations on the person's capacity to get about.

Almost half showed no physical symptoms or limitations on mobility. (Table 3.1) This proportion was larger for persons under 75 than for those over 75 years of age. It was larger for men under 75 than for women, but over 75 there was little difference between the sexes. (See Section 3.25 for more details regarding the distribution of this characteristic.)

3.1.04 Disorders of Organs of Communication

The reported signs and symptoms of physical illnesses of organs of communication were grouped into those which indicated disorders of sight, hearing or speech, and these were classified into severe, 2.6 per cent, and moderate or mild, 11.4 per cent, of the population surveyed.

In men, the frequency of severe disorders of these organs was reported in 1.5 per cent of those between 65 and 74 years of age and in 2.5 per cent of those over 75. In women, severe disorders were reported in 2.5 per cent of those 65-74 and in 4.6 per cent of those over 75. Moderate or mild disorders were reported in 7 per cent of the men 65-74 and were twice as common in the older group. Among women, 11 per cent of those 65-74 were reported to have mild disorders of these organs, and 17 per cent of those over 75 were so reported.

The marked differences between the two sexes are apparent. The higher frequency among women may reflect a higher prevalence of such disorders among women or may be due to an artifact of the survey methods. One possible artifact would be a tendency for women to complain more about the ailments they have. Another might be a greater tendency on the part of the interviewers to question women about such symptoms or to report otherwise equal complaints in more detail or describe them in more impressive terms when they were made by women. On the other hand it may be that certain illnesses occur more frequently among women. Furthermore, there may be a tendency for disorders of speech, hearing and vision in men to be associated with progressive illnesses which shorten life. Such an association would tend to shorten the duration of such disorders in men and so lead to a lower prevalence.

The present data do not permit a definite interpretation of this apparent sex difference. The possible interpretations just offered are intended only to illustrate the multiple types of mechanisms which could be involved—so as to prevent hasty interpretations in our present state of knowledge.

3.1.05 Chronic or Progressive Disease

The reports were used to form a rating of the presence of chronic or progressive physical illnesses. (See Section 3.25) These were grouped as severe (11.5 per cent) and moderate or mild (29.9 per cent). Among men, severe illnesses were reported in 8.4 per cent of persons 65-74 and in 12.5 per cent of persons over 75. Among women, the prevalence of severe physical disorders rose almost not at all with age (12.5 to 13.5 per cent). This difference between the sexes is due to a higher prevalence among women 65-74 than among men of the same age.

It may be seen that for mild and moderate disorders the women also show less rise with age (from 31.7 to 33.7 per cent) than the men (23.2 per cent to 33.8 per cent) and that this is also due to a higher reported prevalence among women than among men in the 65-74-year-old age group.

The factors which might account for this sex difference are the same as the factors which might account for the similar sex differences in the reported prevalence of disorders of communication. (Section 3.1.04.)

However, this difference is present, with respect to chronic or progressive disease, only in the 65-74-year age group and is not present after age 75.

3.1.06 Tremor

Twenty-nine individuals were reported to have tremors. This single sign was tabulated separately in spite of the small number because it is a relatively objective sign. It is more frequently reported among men than among women.

3.1.07 Stroke

Strokes were reported in 45 of the respondents (2.8 per cent). They are more common among men over 75 (5.4 per cent). The 13 cases reported among the 240 men in this age group represent an excess of 6.3 cases over the 6.7 cases which would have been reported had only 2.8 per cent of these 240 men been affected. The number affected should be compared to the seven for whom physical status was not reported.

3.1.08 Limited Physical Movement

About one-fifth of the persons between 65-74 were reported as having limitations of movement; about one-third of the people over 75 were in this category. The two sexes showed no difference in this respect.

3.1.09 Household Members

Over one-fourth of the surveyed population were living as husband and wife in two-person households. This pattern of living was proportionately higher in men than in women (because of the greater number of women in the surveyed population) and was commoner among those less than 75 years of age than among older persons. While this is the modal domestic arrangement for men, women over 75 were found living much more frequently with their children and without their husbands. These differences in age and sex patterns are presumably due to the high mortality rates in this age group and the fact that men have higher mortality rates than women.

Almost one-fifth of the aged population were living alone in apartments or as roomers. This pattern is also commoner among women than among men and was commoner among persons over 75 years of age than among those 65-74. Over a quarter of the women over 75 were living alone.

Over 200 persons (14.3 per cent) were found living as couples in households with their own children; this pattern also varied by age and sex.

Of the total surveyed, 10 per cent were living with unrelated persons.

The 47 persons who were occupying beds in community institutions at the time of the interview represented an increasing proportion of the population with advancing age. This was the condition for 7 per cent of the men over 75 years of age.

3.1.10 Type of Dwelling Unit

About one-third of the population were in single private dwellings, about 44 per cent in apartments or flats, about 11 per cent in the housing project. There are small variations in these percentages by age and sex.

3.1.11 Time Since Last Change of Address

The time since last change of address varies little by age and sex. (There is some suggestion that the women who entered community institutions had been living at their previous addresses for a shorter period than had the men.)

3.1.12 Employment Status

Of the persons under 75, one-half of the men and one-sixth of the women were employed either part- or full-time.

Among women, the drop in employment after 75 is complemented by a corresponding increase in the proportion listed as housewives. However, the drop in the proportion employed among the men is reflected in an increase in persons unemployed. That 14 per cent of the men over 75 were gainfully employed is a fact worthy of note.

3.1.13 Marital Status

While the number of persons in each of the other categories drops with age, the numbers of widowed persons, as expected, rise. It is to be noted that the widowed condition among older people is almost twice as common among women as among men over 75.

3.1.14 Place of Birth

About one-fourth of the persons surveyed were born in Onondaga County, about one-fourth elsewhere in New York State and about one-seventh elsewhere in the United States. Almost one-

third were foreign-born. The foreign-born are more common among the men than among the women.

3.1.15 Education

The extension of high school education which took place at the end of the last century may be reflected in the frequency of persons who had completed one year of a high school education in the two age groups. It is possible, of course, that these statistics reflect wholly or in part differential survivorship experience of the upper economic strata, indexed by higher educational attainments.

3.1.16 Self-Rating of Health

Health self-ratings show some variations with age and sex but do not fall into a striking pattern. It may be noted that "poor" ratings were given by more men over 75 than by men under 75, while among women the "poor" rating was given more commonly under the age of 75.

3.1.17 Desire to Work

Expressions of a desire to work are commoner among men than among women, but vary remarkably little with age.

3.1.18 Satisfaction with Income

There is a slight tendency for persons of each sex over 75 to express less satisfaction with income than do persons under 75.

3.1.19 Loneliness

High and moderate degrees of loneliness were reportedly expressed by almost one-third of the respondents. It was more commonly found among women than among men, and in each sex was more common in persons over 75 than in those 65-74.

3.1.20 Friends and Social Contacts

Few or no friends or contacts were reported by one-third of the surveyed population. This situation was slightly more common among women than among men and increased slightly in frequency with age in both sexes.

3.1.21 Activity in Organizations

Active participation in organizations was reported by 42 per cent of men under 75 and by 31 per cent of those over 75. Among

women the corresponding figure for the younger group is 43 per cent, and 38 per cent for those 75 and over.

3.1.22 Satisfaction with Housing

Satisfaction with housing was expressed by over two-thirds of the population. It did not vary appreciably by age or sex.

3.1.23 Reported Sources of Income

The growing role of social security is strikingly reflected among women in the two age groups, and the declining function of old age assistance also stands out in both sexes.

The wide variety of income sources is striking. The importance of current earnings for a large proportion of this population (about 40 per cent) is remarkable.

3.131 FREQUENCY OF PHYSICAL SYMPTOMS IN MEN AND WOMEN IN DIFFERENT SOCIO-ECONOMIC POSITIONS

Physical symptoms were reported by half the respondents. They were most frequent in women in the households receiving lower socio-economic ratings (62 per cent); next most frequent in men in the households receiving lower ratings (56 per cent), less frequent in women living in households with high socio-economic ratings (47 per cent) and least frequent in men in households with high socio-economic ratings. (Table 3.131)

Table 3.131. Number of Respondents of Different Socio-Economic Groups Reporting Signs and Symptoms of Physical Disease and Disability

Sex and socio-economic group	Number of respondents*	With physical signs and symptoms	
		Number	Per cent of respondents
Both sexes	1,543	786	50.9
High	784	344	43.9
Low	750	442	58.9
Unknown	9	—	—
Men	878	324	47.8
High	332	133	40.1
Low	344	191	55.5
Unknown	2	—	—
Women	865	462	53.4
High	452	211	46.7
Low	406	251	61.8
Unknown	7	—	—

*Exclusive of residents of community institutions.

3.132 FREQUENCY OF COMBINATIONS OF DWELLING UNIT TYPES AND HOUSEHOLD COMPOSITION

Among the 678 men, all combinations tabulated occurred except that, obviously, roomers lived only with nonrelatives by definition. Of every thousand men, 379 were living with their spouses alone in two-person households, accounting for well over half of all men living with their wives. Another 202 men per thousand were living with their wives and children, constituting a prolongation of the nuclear family into later years. Of the remaining men, mostly widowers, 109 per thousand were living with their children, 77 with others than children, and 186 alone as roomers.

The commonest living situation for a man was to be with his wife as a couple in an apartment (170 per 1,000). Couples living in single-family dwellings alone represented 112 in every thousand men. Couples living with children more frequently lived in one-family dwellings (105 per 1,000) than in any other type of housing.

It is twice as common for women to be living alone as it is for men, but the frequency with which they live with nonrelatives is not very different. When they do, they more commonly live in single-family houses and apartments rather than as roomers.

The commonest single combination for women is to be living without their husbands, with their children, in apartments or flats (142 per 1,000); the second most common is the same situation in single-family dwellings (118 per 1,000). This situation is just about as common for women (about one-fourth) as living with wife and children in these two types of housing is for men.

3.133 HOUSEHOLD MEMBERS IN TWO SOCIO-ECONOMIC GROUPS

The proportions of men living alone and with nonrelatives in the lower socio-economic group are respectively more than twice and three times the corresponding proportions in the higher socio-economic group. On the other hand, the proportion of higher socio-economic-level men who live with their spouses and children is more than double that for lower socio-economic-status men.

The proportions of the two socio-economic groups who are classified in the other categories of household types are virtually identical. It is of particular interest to note that this includes the category living with children (mostly widowers) which occurs in both socio-economic strata about 1 in 9.

Table 3.132. Distribution of Respondents* According to Type of Dwelling Unit and Household Composition

Type of Dwelling Unit	Total	Household Composition**						
		Spouse only	Spouse and Children	Spouse and Others	Children Only	Others Only	No Others	Unknown
Total men	1,000	379	202	42	109	77	186	5
One-family	334	112	105	18	38	36	24	1
Apartment or flat	426	170	84	21	60	28	59	4
Housing project	108	80	9	3	3	6	7	—
Room	84	1	—	—	—	—	83	—
Other	44	16	4	—	5	6	13	—
Unknown	4	—	—	—	3	1	—	—
Total women	1,000	227	104	28	277	128	229	7
One-family	336	66	55	8	118	45	43	1
Apartment or flat	478	96	40	18	141	61	117	5
Housing project	119	57	4	2	9	22	25	—
Room	38	1	—	—	—	—	37	—
Other	27	7	4	—	9	—	6	1
Unknown	2	—	1	—	—	—	1	—

*Expressed as frequencies per 1,000, based on the total men (678) and women (865); exclusive of residents of community institutions (24 men and 23 women) and 2 respondents with unknown ages (1 man and 1 woman).

**Households containing spouses and/or children are classified accordingly, regardless of the presence of others, such as grandchildren, in the household; the category, "others only," indicates that the household contains either nonrelatives or relatives who do not include a spouse or child.

The socio-economic-status pattern in distribution of household types differs somewhat for women from the pattern observed for men. Women, like men, live alone more frequently in lower socio-economic groups; living with spouse and children occurs proportionately more frequently (almost twice as often) among higher socio-economic-status women. However, no significant difference occurs, for the category living with nonrelatives, and living with children only (consisting mostly of widows) occurs about half again as frequently among the higher socio-economic group of women as among the lower (32.5 per cent to 22.7 per cent).

Table 3.133. Men Respondents According to Socio-Economic Rating and Household Composition

Household composition*	Total	Socio-economic rating		
		High	Low	Unknown
Total men respondents**	678	332	344	2
Total per cent	100.0	100.0	100.0	100.0
Spouse only	37.9	39.5	36.3	50.0
Spouse and children	20.2	28.0	12.8	—
Spouse and others	4.1	4.5	3.5	50.0
Children only	10.9	11.1	10.8	—
Others only (relatives)	6.3	6.3	6.4	—
Others only (nonrelatives including roomers)	9.6	4.2	14.8	—
No others	10.3	6.0	14.5	—
Unknown	0.6	0.3	0.9	—
Total women respondents**	865	452	406	7
Total per cent	100.0	100.0	100.0	100.0
Spouse only	22.7	20.8	25.1	0
Spouse and children	10.4	13.3	7.4	0
Spouse and others	2.8	1.3	4.2	14.3
Children only	27.7	32.5	22.7	14.3
Others only (relatives)	11.3	11.7	10.6	28.6
Others only (nonrelatives including roomers)	5.2	5.1	4.9	28.6
No others	19.2	14.8	24.1	14.3
Unknown	0.7	0.4	1.0	0

*Households containing spouses and/or children are classified accordingly, regardless of the presence of others, such as grandchildren, in the household; the category, "others only," indicates that the household contains either nonrelatives or relatives who do not include a spouse or child.

**Exclusive of residents of community institutions and respondents with unknown age.

3.134 THE TYPES OF HOUSING OCCUPIED BY RECENTLY-MOVED MEN AND WOMEN

The 217 men who have moved to their present addresses within the past five years are found less frequently (about 1 in 6) in single-family dwellings than are the 463 men who have been at their present addresses over five years. Recently-moved men also occupy apartments and flats more rarely and more frequently occupy quarters in the housing project, rented rooms and other arrangements.

The picture for the women is similar to that reported for the men.

Table 3.134. Length of Residence of Respondents at Survey Address by Type of Dwelling Unit

Type of dwelling unit	Total	Number of years				Unknown
		Less than 5	5 to 9	10 to 19	20 or more	
Men						
Total number*	678	217	111	118	230	2
Total per cent	100.0	100.0	100.0	100.0	100.0	—
One family	33.3	16.1	30.6	20.3	57.8	—
Apartment or flat ..	42.6	37.8	44.1	58.5	37.8	—
Housing project	10.8	21.2	13.5	10.2	0.0	—
Room	8.4	17.5	8.1	5.1	1.7	—
Other	4.4	6.9	3.6	5.1	2.2	—
Unknown	0.4	0.5	0.0	0.8	0.4	—
Women						
Total number*	865	262	145	155	299	4
Total per cent	100.0	100.0	100.0	100.0	100.0	—
One family	33.6	17.6	22.1	29.7	54.8	—
Apartment or flat ..	47.7	46.9	57.2	52.9	41.5	—
Housing project	11.9	24.4	15.2	11.0	0.0	—
Room	3.8	8.0	3.4	3.9	0.3	—
Other	2.7	3.1	1.4	2.6	3.0	—
Unknown	0.2	0.0	0.7	0.0	0.3	—

*Exclusive of respondents who were residents of community institutions (men, 24; women, 23) and those whose age was unknown (men, 1; women, 1).

3.135 EMPLOYMENT IN MEN RELATED TO AGE AND OTHER FACTORS

About half of the men in the age group 65-74 are still employed, mostly full time. The proportion of employed men, however, drops sharply to about 15 per cent in the age group 75 and over.

Table 3.1351. Employment Status Among Men by Age

	Age	
	65-74	75+
Employed	49.7	15.2
Not employed	49.9	74.8
Unknown	*	—
Number	455	223
Per cent	100.0	100.0

Table 3.1352 shows that of those not employed, 61 per cent said they were *not* interested in employment. Some cited such reasons as having worked long enough and being entitled to rest, or as feeling physically unfit for work.

Motivations for seeking work are complex. Some men clearly stated that their interest in seeking work was based on their need for money, despite their feeling that work would impose a heavy physical burden upon them.

Table 3.1352. Expressions of Employed and Retired Men Respondents 65 to 74 Years of Age with Respect to Desire to Work

Employment status	Total number	Total per cent	Desires to Work			
			Part time or light	Other	Does not desire to work	Unknown*
Total respondents**	455	100.0	6.2	12.1	34.7	47.0
Employed	226	100.0	4.9	19.0	8.4	67.7
Retired	227	100.0	7.5	5.3	61.2	26.0
Unknown	2	100.0	0.0	0.0	0.0	100.0

*Includes unclassified.

**Exclusive of residents of community institutions (7 respondents).

Table 3.1353 shows that employment status corresponds to different frequencies of symptoms among men 65-74. Among the employed men, less than a quarter reported one or more signs or symptoms of physical disease whereas 58 per cent of the "retired men" were reported to have symptoms of physical disorder which were judged to handicap physical activity. The other unemployed men in this age group expressed an interest in employment opportunities. Some (spontaneously) expressed a preference for part-time or light work.

Table 3.1353. Employment Status of Men Respondents 65 to 74 Years of Age According to Reported Signs and Symptoms of Physical Disease and Disability

Signs and symptoms of physical disease	Total No.	Total Per cent	Employment status					
			Employed		Retired		Unknown	
	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Total respondents*	455	100.0	226	100.0	227	100.0	2	100.0
No signs or symptoms reported	259	56.9	170	75.2	89	39.2	0	0
One or more signs or symptoms reported	182	40.0	50	22.1	132	58.1	0	0
Unknown	14	3.1	6	2.7	6	2.6	2	100.0

*Exclusive of residents of community institutions.

Table 3.1354 shows a similar relationship between employment status and self-rating of health. About 70 per cent of the employed men report they are in good health as compared with but 37 per cent of those "retired."

Table 3.1354. Employment Status of Men Respondents 65 to 74 Years of Age According to Self-Rating of Health

Self-rating of health	Total No.	Total Per cent	Employment status				Unknown
			Employed		Retired		
			No.	Per cent	No.	Per cent	
Total*	455	100.0	226	100.0	227	100.0	2
Good	245	53.8	161	71.2	84	37.0	0
Fair	150	33.0	53	23.5	97	42.7	0
Poor	49	10.8	9	4.0	40	17.6	0
Unknown	11	2.4	3	1.3	6	2.6	100.0

*Exclusive of residents of community institutions (7).

Table 3.1355 shows that the proportion of men who were employed varies by marital status in each of the two age groups.

Table 3.1355. Employment Status of Men Respondents According to Age and Marital Status

Age and marital status	Number of respondents	Employed	
		Number	Per cent of respondents
Total*	678	260	38.3
Married	433	192	44.3
Widowed	151	33	21.9
Divorced and separated	41	20	48.8
Single	50	14	28.0
Unknown	3	1	33.3
Age 65 to 74	455	226	49.7
Married	318	171	53.8
Widowed	72	24	33.3
Divorced and separated	25	17	68.0
Single	38	13	34.2
Unknown	2	1	50.0
Age 75 and over	223	34	15.2
Married	115	21	18.3
Widowed	79	9	11.4
Divorced and separated	16	3	18.8
Single	12	1	8.3
Unknown	1	—	—

*Exclusive of residents of community institutions.

Table 3.1356 shows that employment is commoner among men who have had more education both in the age group 65-74 and in the age group 75+, at least among those born in New York State.

Table 3.1356. Employment Status of Men Respondents Born in New York State According to Age and Education

Age and education	Total number	Total per cent	Employment status		
			Employed	Retired	Unknown
Total*	329	100.0	39.8	59.9	0.3
Grade school or less	195	100.0	33.8	65.6	0.5
Some high school or more	101	100.0	48.5	51.5	0.0
Unknown	33	100.0	48.5	51.5	0.0
Age 65 to 74	217	100.0	52.1	47.5	0.4
Grade school or less	122	100.0	46.7	52.5	0.8
High school or more	74	100.0	58.1	41.9	0.0
Unknown	21	100.0	61.9	38.1	0.0
Age 75 and over	112	100.0	16.1	83.9	0.0
Grade school or less	73	100.0	12.3	87.7	0.0
Some high school or more	27	100.0	22.2	77.8	0.0
Unknown	12	100.0	25.0	75.0	0.0

*Exclusive of residents of community institutions.

3.2 THE DISTRIBUTION OF CASES OF MENTAL DISORDER

3.21 General Pattern

One hundred persons were rated certifiable by the method described in Section 1.35. Half of these were men and half were women.

These cases were identified from a population of 1,805 enumerated persons over 65 years of age, of whom 815 were men and 990 were women. The enumerated men rated certifiable amounted to 6.1 per cent; and 5.0 per cent of enumerated women were rated certifiable.

Of the enumerated population, 1,592 were interviewed and rated. Of these 703 were men and 889 were women. The interviewed men who were rated certifiable amounted to 7.1 per cent; the interviewed women who were rated certifiable reached 5.6 per cent.

Because the number of uninterviewed persons in the enumerated population (213) is twice as large as the number of persons found to be certifiable (100), differences between the percentages of certifiables in any subgroups of the surveyed population can-

Table 3.21-1. Age and Sex Distributions

Age (years)	65-69	70-74	75-79	80-84	Un-		Total
					85 known		
Both sexes							
Enumerated population	699	499	312	193	97	5	1,805
Interviewed	622	446	280	169	73	2	1,592
Rated certifiable	20	19	23	16	22	0	100
Per cent of interviewed ..	3.2	4.3	8.2	9.5	30.1	0	6.3
Men							
Enumerated population	324	216	143	92	36	4	815
Interviewed	272	190	130	82	28	1	703
Rated certifiable	12	6	13	9	10	0	50
Per cent of interviewed .	4.4	3.2	10.0	11.0	35.7	—	7.1
Women							
Enumerated population	375	283	169	101	61	1	990
Interviewed	350	256	150	87	45	1	889
Rated certifiable	8	13	10	7	12	0	50
Per cent of interviewed ..	2.3	5.1	6.7	8.0	26.7	—	5.6

not be interpreted with confidence. This *caveat* must be kept firmly in mind in addition to the other obvious limitations of the data.

In the following presentation and discussion of the data, the distribution of the unknowns is displayed, along with the distribution of the certifiable cases and the interviewed persons not found to be certifiable. It will be observed that the frequency of the unknowns varies considerably in the subsections of the population.

The data are examined first to see if there is a difference in the prevalence of certifiables in the various subgroups of the *interviewed* population; second to see if these differences are attributable to chance variation in small numbers; third to discuss the possible effect of selective bias in the prevalence of certifiables among the unknowns. In general, it may be said that observed differences in the prevalence of certifiables in different subgroups of the interviewed population, even when the observed differences are highly improbable as chance phenomena, could be due to special characteristics of the un-interviewed population. Some information is given about the unknowns in terms of the facts gathered in the enumeration. This information may be used to help form judgments regarding the frequency with which certifiable cases are concealed among the 213 persons who were enumerated but un-interviewed, and to help judge in which subsections of the enumer-

ated population they might be, but there is no apparent way to determine how many and where they would be from these data. Many speculations are possible regarding the distribution of cases among these unknowns; but it is not the object of this report to discuss the possible speculations.

(It is somewhat discouraging to place so much emphasis upon the fact that nothing is known about the mental health status of 213 persons among the 1,805 enumerated and that this is more than twice as many people as there were certifiable persons. On the other hand, it is perhaps relevant to point out in this context that this represents considerable progress in reducing the size of the unknown population, as compared to its size prior to the survey. At the time of the survey, there were in mental hospitals with clinical psychiatric records 23 persons who could be regarded as members of this population of elderly people. These constitute about 1.3 per cent of the population. The other 98.7 per cent were totally unknown regarding mental status, and all notions regarding the distribution of cases of severe disorder among these 98.7 per cent were either purely speculative or highly inferential from tangentially relevant data. This figure of 98.7 per cent has been reduced through the process of this survey to 11.5 per cent. It is clear that this reduction in the percentage of persons about whom no information is available is considerable; however, it is also clear that this is not enough of a reduction if certain types of important questions are to be answered.)

3.22 Age and Sex Distributions

From these data it may be seen that among the interviewed the prevalence of certifiable cases rises with age in each sex. The differences between the two sexes are not significant. If the unknowns had been interviewed, a significant difference might have emerged if the unknowns had been found to contain a large proportion of certifiable individuals in one sex and few or none in the other. The shape of the prevalence curve which ascends with age could also be radically changed by the presence of an extreme bias among the unknowns. (Obviously, if one assumes that the prevalence rates among the whole enumerated population are the same as those found among the interviewed population, one is assuming that the prevalence of cases among the un interviewed is the same as among the interviewed.) Even extreme assumptions

regarding the distribution of cases among the unknowns would not, however, entirely eliminate the presence of a rise in prevalence with age in each sex.

3.23 *Persons in the Nursing Homes and in the County Home*

The interviewers went to the licensed nursing homes in the county and to the Onondaga County Home, and identified 54 persons over 65 years of age with addresses of record within the surveyed census tracts. Of these, 47 were successfully interviewed.* Of these 47, 18 were rated as certifiable. This number reflects a prevalence rate of 46 per cent among the interviewed men in these institutions and of 30 per cent among the interviewed women. The distribution of persons and of certifiable cases by age and sex is shown in Table 3.23-1.

Table 3.23-1. Persons in Nursing Homes and in the Onondaga County Home

Age (years)	65-69	70-74	75-79	80-84	85	Unknown	Total
Men							
Total	5	5	7	9	3	0	29
Interviewed	2	5	6	8	3	0	24
Rated certifiable	2	0	3	4	2	0	11
Women							
Total	2	3	6	5	9	0	25
Interviewed	2	3	6	4	8	0	23
Rated certifiable	1	1	1	0	4	0	7

3.24 *Variations in Prevalence of Certifiability Among Persons Living in Homes of Different Socio-Economic Ratings*

In Section 1.2 the socio-economic rating assigned to homes was described. In Tables 3.24-1 and 2 the prevalence of certifiability by age for each sex is shown, the persons living in homes rated A or B or C being tabulated separately from those living in homes rated D or E. From this it is apparent that the group which is most distinguished from the others is that shown by the prevalence rates for men living in homes rated A or B or C. This group is distinguished by extraordinary low rates for the years before the eighty-fifth birthday when compared to the other three groups. The fact that the prevalence falls with age in this group between 65 and 80 suggests, even with the small number of men involved

*Grateful acknowledgment is made to the managers of the institutions for their co-operation and help.

Table 3.24-1. Socio-Economic Scores of Enumerated, Interviewed and Certifiable Populations

Age (years)		65-69	70-74	75-79	80-84	85+	Un- known	Total
Women —	Enumerated	375	283	169	101	61	1	990
	Interviewed	350	256	150	87	45	1	889
	Certifiable	8	13	10	7	12	0	50
Scored A	Enumerated	4	0	1	1	3	0	9
	Interviewed	4	0	1	1	2	0	8
	Certifiable	0	0	0	0	0	0	0
B	Enumerated	17	18	12	11	7	1	66
	Interviewed	14	14	10	11	6	1	56
	Certifiable	0	0	0	0	1	0	1
C	Enumerated	163	138	75	42	27	0	445
	Interviewed	152	125	64	33	16	0	389
	Certifiable	3	5	4	4	4	0	20
D	Enumerated	169	108	62	37	13	0	389
	Interviewed	160	100	59	33	11	0	363
	Certifiable	4	7	3	3	3	0	20
E	Enumerated	17	12	13	5	2	0	49
	Interviewed	15	10	9	5	2	0	41
	Certifiable	0	0	2	0	0	0	2
Men —	Enumerated	324	216	143	92	36	4	815
	Interviewed	272	190	130	82	28	1	703
	Certifiable	12	6	13	9	10	0	50
Scored A	Enumerated	29	1	0	0	0	0	30
	Interviewed	0	1	0	0	0	0	1
	Certifiable	0	0	0	0	0	0	0
B	Enumerated	16	11	8	3	3	1	42
	Interviewed	13	9	7	3	0	0	32
	Certifiable	0	0	0	0	0	0	0
C	Enumerated	152	99	50	35	13	2	351
	Interviewed	131	81	46	31	10	1	300
	Certifiable	4	2	1	1	5	0	13
D	Enumerated	117	86	66	40	14	1	324
	Interviewed	102	81	59	35	12	0	289
	Certifiable	5	4	6	2	2	0	19
E	Enumerated	31	13	11	5	3	0	63
	Interviewed	24	12	11	5	3	0	55
	Certifiable	1	0	3	2	1	0	7

Table 3.24-2. Prevalence of Certifiable Persons Among Those Interviewed in Two Socio-Economic Groups

Age (years)	65—	70—	75—	80—	85—	Unknown	Total
Men							
A+B+C							
Interviewed	144	91	53	34	10	1	333
Per cent certifiable ..	2.8	2.2	1.9	2.9	50.0		3.9
D+E							
Interviewed	126	93	70	40	15	0	344
Per cent certifiable ..	4.8	4.3	12.9	10.0	20.0		7.6
Women							
A+B+C							
Interviewed	170	139	74	45	24	1	453
Per cent certifiable ..	1.8	3.6	5.3	8.9	20.8		4.6
D+E							
Interviewed	175	110	70	38	13	0	406
Per cent certifiable ..	2.3	6.4	7.1	7.9	23.1		5.4

NB. Besides the 54 persons in community institutions (see Table 3.23-1) there were seven women and three men who were not assigned a socio-economic rating.

in this part of the study, either that the duration of certifiability among men living in homes rated A, B or C is less than among women in these age intervals, and may be less than among men living in homes rated D or E on the socio-economic scale, or that the incidence declines with age. The fact that the prevalence curves for men in both economic groups decline, is in contrast to the women's prevalence curves which rise in every age interval.

Attention to the marked contrast of the men rated A, B or C, as compared to those rated D or E should not obscure the lesser contrast between the economic groups among women under the age of 80, women in the lower economic groups having a higher prevalence of certifiability than women in the higher economic groups up to this age.

The fact that prevalence rates of certifiable cases differ more markedly among men of different economic groups than they do among women of different economic groups is capable of several interpretations. It may be regarded as evidence that the environment of men of different social groups varies more greatly than does the environment of women, particularly with respect to work. It may be regarded as a reflection of greater sensitivity to environmental variations on the part of men than on the part of women. It might be attributed to selection into social groups of men pre-

destined for either early mental disorders or for prolonged mental health. It might also be attributed to early stages of the illnesses which lead to certifiable disorders, since men experiencing physical illnesses which tend to be accompanied by mental disorder (particularly cerebral arteriosclerosis) may lose earning capacity earlier, and so be subject to an economic downward "drift" which would produce a concentration of cases among the economically lower population. Presumably such illnesses among women would not have such a marked effect on family finances. In a period of general upward social mobility, the same effect might be obtained as a result of chronic disorders among men limiting the family upward mobility more than such illnesses in women would do.

Each of these arguments assumes that variations in prevalence rates are a reflection of variations in incidence rates. It is clear that, with or without this assumption, this differential in relation of prevalence rates to social class, as between men and women, could be the result of several different mechanisms. The mechanisms outlined are illustrative only; their purpose is to underline the importance of the phenomenon and to indicate the difficulty of offering a definite explanation for it in our present limited state of knowledge.

Furthermore, interpretation of these data is limited by the unknowns. A large proportion of certifiables among the unknowns in the ABC group combined with few or no certifiables among the unknowns in the DE group could reduce or eliminate the observed differences.

3.25 Physical Disability in Relation to Certifiability

Tabulations from the interviewers' ratings under the headings of symptoms of physical disorders suggested an association between their data regarding physical disorders and certifiability. Because the ratings assigned by the interviewers were not consistent, but the information regarding physical illness was often useful, the protocols were all reviewed by a physician-psychiatrist member of the research staff who had joined the staff during the period when the data were being analyzed. On the basis of all the information available in the interviewers' protocols, he assigned a rating of "severe progressive or chronic physical illness" to those persons for whom definite evidence of such a condition was recorded. He also assigned a rating of "severe limita-

tion of physical activity" where he judged the evidence to justify such a rating. Persons judged to have either of these conditions have been designated "severely physically disabled."

The prevalence of certifiability was much higher among those who were severely physically disabled than among those who were not. It may be seen that the prevalence of certifiability among those who were not severely physically disabled rises with age in both sexes. Among those who were severely physically disabled, the prevalence of certifiability also rises with age in women; but among the men this is not so marked. The difference between the prevalence of certifiability among those severely physically disabled and among others is much greater in men in the 65-74-year age group (20.0 per cent as compared to 2.2 per cent) than it is in women (5.0 per cent as compared to 3.3 per cent).

The stronger relationship between severe physical disability, and the prevalence of certifiability, among men than among women in the 65-74-year age group might be due to systematic error in gathering and organizing the data. First, 78 men and 52 women in this age group were omitted from the analysis because insufficient data were obtained. It might be that sick women were missed systematically more than sick men because of protective attitudes on the part of families toward women. In this connection it is important to note that the prevalence of certifiability in all men and in all women in the age group 65-74 did not differ significantly; such a systematic bias would also result in a relative underestimation of the prevalence of certifiability in the women and would have concealed an over-all difference between the sexes in the prevalence of certifiability. The fact that the three-year mortality rate for 65-74-year-old men whose status was unknown (9.0 per cent) was not significantly different from that for unknown women in this age group (7.7 per cent) argues against the assumption that a systematic bias entered into case-finding with respect to physical illnesses. Second, in conducting the interviews, the interviewers may have interjected certain preconceptions regarding this association, either by pressing or failing to press for certain classes of information, or by emphasizing information which seemed to form a picture in their minds. Since such a set of preconceptions might be expected to be different among medical students than in the other interviewers, this analysis is re-examined by dividing the interviewers into two groups

on the basis of professional background (Section 3.251). A third possible bias could have been introduced in the denominators of the rates: Women in the 65-74-year age group may have been relatively more easily assigned to the severely physically disabled category as compared to men. This would have inflated the physically disabled part of this population and thereby would reduce the rate of certifiability in those classified as physically disabled. Such a systematic relative difference in the assignment of physical disability to the populations of the two different sexes would have had to occur on a rather large scale to produce the differences observed.

Because the scattering of persons in the A, B and E households might have played an important role in producing the contrast between this association in men and women, the same data were examined with respect only to the population living in C and D households. Although the percentages were somewhat modified in value, the contrast is equally marked. Likewise, it was thought possible that this pattern of association between physical disability and mental disability might be largely attributable to the population living in nursing homes or in the county home. But when the analysis is confined to persons living outside of such institutions, the basic pattern described persists.

3.251 THE ROLE OF INTERVIEWERS' PROFESSIONAL TRAINING IN PRODUCING THE ASSOCIATION BETWEEN THE PREVALENCE OF CERTIFIABILITY AND OF SEVERE PHYSICAL DISABILITY

Because of the importance of the association between the prevalence of certifiability and of severe physical disability, the role of possible preconceptions by interviewers was considered. In order to obtain data to provide an indication of the role which such preconceptions might have played, the group of interviewers was divided into two parts: those who were third-year medical students and the other interviewers. While other bases for classifying the interviewers could be used, this classification is based upon prior knowledge regarding physical illnesses and prior experience in eliciting symptoms and signs of physical illness.

In Table 3.251, the association is re-examined.

Illness of both types, associated and unassociated, tended to be found more frequently in the population interviewed by the medi-

Table 3.25. Prevalence of Certifiability in Those with Severe Physical Disability Compared to Other Persons

	Age (years)	65-74	75+	Total*
Men				
Enumerated		540	271	815
Interviewed		462	241	703
With severe physical disability		45	46	91
Per cent certifiable		20.0	32.6	26.4
Others, per cent certifiable		2.2	8.8	4.2
Women				
Enumerated		658	331	990
Interviewed		606	282	889
With severe physical disability		87	50	137
Per cent certifiable		5.0	20.0	10.2
Others, per cent certifiable		3.3	8.2	4.8

*Including persons of unknown age.

cal students. (There was no indication of the professional backgrounds or names of the interviewers on the protocols examined by the raters; and some of the raters had never even met the interviewers.)

The data provided by both groups of interviewers, however, leads to the conclusion that in persons 65-74 severe physical disability is more closely associated with certifiability in men than in women.

3.252 THE PEOPLE WITH STROKES

The physician-reviewer also rated those protocols which gave definite evidence of a recent stroke. Thirty-five persons were identified as having had strokes, of whom 10 were regarded as being certifiable. Because the difference between the association of mental disorders and of severe physical disability might reflect a difference in the distribution of cerebral arteriosclerotic disease in men and women in the 65-74-year age group, the distribution of stroke cases is of particular interest.

	65-74		75 and over	
	Strokes	Certifiable	Strokes	Certifiable
Men	13	5	14	5
Women	14	2	6	2

While no definitive conclusions can be drawn, these findings are in conformity with other evidence that strokes are more common in men than in women over the age of 75. It is possible that post-

Table 3.251. Prevalence of Certifiability in Those with Severe Physical Disability Compared to Other Persons; Two Classes of Interviewers Compared

Age (years)	65-74	75+	Total*
Medical Student Interviewers			
Men			
Enumerated	213	132	346
Interviewed	193	125	318
With severe physical disability	24	29	53
Per cent certifiable	20.8	37.9	30.1
Others, per cent certifiable	3.6	13.5	7.2
Women			
Enumerated	284	158	438
Interviewed	267	132	401
With severe physical disability	39	22	61
Per cent certifiable	5.1	22.7	11.5
Others, per cent certifiable	3.9	9.0	5.6
Other Interviewers			
Men			
Enumerated	327	139	469
Interviewed	269	115	385
With severe physical disability	21	17	38
Per cent certifiable	19.0	23.5	21.0
Others, per cent certifiable	1.0	4.1	2.0
Women			
Enumerated	374	183	557
Interviewed	339	149	488
With severe physical disability	48	28	76
Per cent certifiable	4.2	14.7	9.2
Others, per cent certifiable	2.7	7.4	4.12

*Including persons of unknown age.

stroke conditions are more commonly associated with severe mental disorder in men in the age group 65-74 than they are in women.

These cases do not, however, entirely account for the higher association in men than in women between severe physical disability and certifiable mental states in the age group 65-74. There is a possibility that milder strokes and other forms of cerebral arteriosclerosis might lie behind the stronger association in men than in women of mental disorders in the severe physical disability in the 65-74 age group.

3.26 THE CERTIFIED CASES

It is of interest to consider the portion of the survey population which had been certified as well as the portion rated as certifiable in the survey. (Table 3.261-1.)

Table 3.261-1. Number of Patients in Mental Hospitals from Syracuse (1 June—30 September, 1952) and Prevalence Rate, Per Cent, of Hospital Cases

Age (years)	65-69	70-74	75-84	85+	Unknown	Total
Men						
Population*	3,851	2,585	2,351	350		9,137
Hospital cases	17	25	33	14	3	92
Per cent in hospital	0.44	0.97	1.40	4.00		1.01
Women						
Population*	4,521	3,331	3,237	655		11,744
Hospital cases	29	24	52	18	4	127
Per cent in hospital	0.64	0.72	1.61	2.75		1.08

*According to 1950 Federal Census.

In this study, certified persons were defined as individuals admitted after 1946, to the mental hospitals which serve Syracuse, who were on the books of a mental hospital at any time during the summer of 1952 (April 1 to September 1), who had been born prior to 1883, and whose residence was in one of the six surveyed tracts.

This definition is arbitrary, in that persons in this age group admitted prior to 1947 were excluded. This procedure was based on the fact that allocation of a chronically institutionalized person to a noninstitutional community population becomes less and less appropriate the longer the individual has been institutionalized. The membership of the individual in the noninstitutional population becomes more questionable. The portion of the noninstitutional population to which he should be assigned becomes more dubious, since the structure of his family, the household of which he was once part, and even the residence in which his family lives, are more likely to have changed. In addition, in attempting comparisons between one part of a city and another, it must be recognized that older parts of the city have had opportunities to send people to the institution over a longer period of time than have the younger parts of the city. In selecting the year 1947 for admissions, consideration was given to the fact that the average duration of mental hospital life among persons dying in the mental hospitals of New York State with a diagnosis of senile psychosis was 1.9 years, and the duration with a diagnosis of cerebral arteriosclerotic psychosis was 2.1 years, both as of 1952.*

*New York State Department of Mental Hygiene Annual Report for 1952, p. 146.

3.261 FROM THE CITY OF SYRACUSE

There were 219 persons who met these criteria in the mental hospitals from the city of Syracuse. Of these, 23 had addresses in the six surveyed tracts. The population over 65 years of age in the whole city at that time was estimated at 20,881. The prevalence of certified persons over 65 in the whole city was thus 1.05 per cent. The distribution of these cases and of the 1950 Census Bureau's report of population by age and sex are shown in Table 3.261-1. The percentage of the population in each age and sex group which was in mental hospitals (according to the criteria explained previously) is shown.

It may be seen from this table that the prevalence of hospitalized cases rises with age in the two sexes. Even using the whole population of Syracuse in these age groups, the number of cases is too small to yield stable enough rates to justify serious attention to the differences in rates between the two sexes. However, in each sex, it is clear that the prevalence rate is very much affected by chronological age of the population at risk.

3.262 PREVALENCE OF CERTIFIED CASES FROM THE SURVEYED
CENSUS TRACTS BY AGE AND SEX

There were eight certified men identified by the method described in the previous section whose addresses of record were in one of the surveyed tracts. The crude prevalence rate among the 815 enumerated men was thus 0.98 per cent. However, even this small number of cases was not evenly distributed at different ages. Despite the small number, their age distribution is reported here.

Age:	65-	70-	75-	80-	85-	All
Number of certified persons	3	1	2	1	1	8
Prevalence rate, per cent	0.9	0.5	1.4	1.1	2.8	1.0
(in enumerated population)						

There were twice as many certified persons, 15, attributable to the 978 women enumerated. They were distributed as follows:

Age:	65-	70-	75-	80-	85-	Unknown	All
Number of certified persons ..	3	7	4	0	0	1	15
Prevalence rate, per cent ..	0.80	2.5	2.4	0	0		1.5

Since these numbers are so small that an additional case or two randomly assigned to the different cells would change the apparent pattern, it is not possible to draw any conclusions from the apparent differences exhibited in the different age and sex groups. For example, if the 51 women over the age of 85 had had the same prevalence of certified cases as all the 655 women of the same age group in the city had, they would have been expected to exhibit 1.7 cases.

3.27 Prevalence of Certified and Certifiable Cases

3.271 CERTIFIED AND CERTIFIABLE PREVALENCE BY CENSUS TRACT

In Section 1.121, the method of selecting the tracts for surveying was described. It was pointed out there that the population was selected with the hope that the findings from the survey would provide an opportunity to study the relationship between extreme variations in mental hospital rates, and variations in the occurrence of mental disorders in the population served by the hospitals.

Table 3.271-1 shows the distribution of certified cases by census tract, the enumerated population and the percentage of the enumerated population found to be in hospitals. As is apparent, even with these small figures, the age distributions of the populations of the different census tracts could have an effect on the rates. The last column of Table 3.271-2, labeled "O-E," shows the net difference in the number of hospital cases found and the number which would have been expected, had each age and sex group in the population of each census tract had cases in the hospital at the same rate as had the corresponding age and sex group of Syracuse as a whole, as determined by the usual method of indirect standardization. It may be seen that the surveyed tracts as a whole had an excess of 6.8 cases.

The numbers involved in this table are really too small to justify any firm classification of some census tracts as high hospital prevalence tracts and others as low prevalence tracts. The last column shows that the differences in prevalence rates (from 0.3 to 2.2 per cent) are based on differences of only three or four cases in the numbers found in any one census tract.

The fact that the data here do not reveal significant differences in the crude prevalence rate of certified persons is due to the small numbers involved. If the populations of census tracts are combined on the basis of socio-economic areas (See Section 2.21),

Table 3.271-1. Prevalence of Certified Hospital Cases by Census Tract

Census Tract	Hospital Cases	Enumerated Population	Prevalence Per cent	O-E*
42	6	504	1.2	+2.4
41	6	287	2.0	+3.0
27	4	286	1.4	+0.9
5	2	208	1.0	-0.1
18	1	341	0.3	-1.4
49	4	179	2.2	+2.0
Total	23	1,805		

*Based on city-wide age and sex specific rates (Table 3.261-1) applied to Enumerated Population of each census tract.

larger populations can be obtained, and the prevalence rates of certified persons can be made more stable. However, the rates for Area III tracts (census tracts 49 and 18) and for Area VI tracts (census tracts 41, 5 and 42) do not differ significantly from the over-all city-wide prevalence figure.

If the observed distribution of cases is used to group the tracts, more reliable differences between groups can be obtained. This "reliability" is possibly illusory, however, since the basis for grouping the tracts is the way in which the small number of hospital cases is distributed. On the basis of the figures shown in Table 3.271-1, three groups of tracts might be selected: high prevalence tracts 41 and 49, medium prevalence tracts 42 and 27, and low prevalence tracts 5 and 18. The relevant data are presented in Table 3.271-2 along with the figures appropriate for comparing them with respect to the survey prevalence of certifiable cases.

It may be seen that these data grouped in this way give the impression that the tracts selected as high and low with respect to the prevalence of hospitalized certified patients both showed about the same prevalence of certifiable persons in the survey, while the two tracts selected as medium with respect to the prevalence of hospitalized certified patients had a higher prevalence of certifiable persons in the survey.

These data are completely inconclusive because, as already stated, the grouping of the tracts is based on too small a number of hospitalized cases, and the frequency of the unknowns in the survey population was so great that the observed variation in the prevalence of certifiable persons in the interviewed populations of the different census tracts is not a satisfactory measure of the

Table 3.271-2. Census Tracts Grouped by Prevalence of Hospital Certified Patients, and These Groups Compared as to Prevalence of Certifiable Persons Found in the Survey

	High			Medium			Low					
	CT No.	Pop.	Prevalence Per cent	O-E*	CT No.	Pop.	Prevalence Per cent	O-E*	CT No.	Pop.	Prevalence Per cent	O-E*
Certified Patients (Enumerated Populations)	41		2.03	3.0	42		1.18	2.4	5		0.96	-0.1
Totals	49		2.20	2.0	27		1.38	0.9	18		0.29	-1.4
				5.0				3.3				-1.5
Certifiable Persons (Interviewed Populations)	41	254	5.51	-1.7	42	416	8.41	5.0	5	190	6.84	2.2
Totals	49	409	5.62	-2.8	27	706	7.51	9.8	18	477	5.03	-2.6

*O-E figures for certified persons are those of Table 3.271-1.

O-E figures for certifiable persons are obtained by applying the rates shown in Table 3.21-1 to the interviewed populations of the indicated pairs of census tracts.

variations in the prevalence of such persons in the enumerated populations of the different census tracts. These data are presented here in this manner because, when organized in this way, their relevance to the issue of census tract variation can be seen clearly.

But there are other reasons why the comparison of census tract prevalences of the certified and certifiable proved difficult or impossible to make. It had been assumed that the surveyed tracts would fall within groups with different proportions of the population in mental hospitals. It had also been assumed that it would be possible to identify the census tract of origin of those in the hospital from the central statistical office's records of home addresses of patients in mental hospitals. However, it was found in the process of gathering these data that these records do not provide home addresses by the same criteria as was done in obtaining the home addresses of first admissions in the previous study.* The central office records of home address were influenced more by the location of financially responsible relatives than had been the individual hospital's records from which the earlier data had been obtained.

The possibility of obtaining home addresses from the active case records of the various hospitals was considered. However, it was concluded that these data would not be worth the large effort necessary to obtain them. This conclusion was reached upon examination of the information contained in the previous sections. From these data, it appears that nursing homes and county homes, at least in this population, were providing considerable residential care for persons with certifiable mental disorders. The number of cases in these locations (18) was near the number in mental hospitals (23). Other sources of information which became available in 1952 and the following few years tended to confirm the impression that care away from home for persons with mental disorders as severe as those of persons who went to mental hospitals was being provided by other types of facilities in addition to the mental hospitals. If, as seems to be the case, this has become a pattern of increasing frequency since the second World War, the relevance of mental hospital cases, studied by themselves, has become less. To study the distribution of cases being cared for away from home, it would be desirable to study both the mental

*Gruenberg, E. M.: *Op. cit.*

hospital and the other institutional cases simultaneously. To get a city-wide pattern of such cases by census tracts, it would be necessary to get the home addresses of the mental hospital cases (from the hospital record rooms) and at the same time screen the persons in nursing homes, county homes, and general hospitals, and chronic disease hospitals, by some such method as was used in this survey, in order to identify the persons with severe mental disorders who were there.

Such a study might produce useful findings. Had the value of such a procedure been appreciated at the time this survey was conducted and interviewers trained, the whole Syracuse population in nursing homes, the county home and general hospitals in this age group could have been screened with only a small additional effort. Had those data been gathered, it probably would have been worth while to make a careful search of the mental hospital records and make proper census tract allocations from them. From such a procedure, data might be obtained worth studying in terms of a city-wide pattern. However, it should be kept in mind that this is a laborious and expensive undertaking and that, although data which could be organized in a sensible fashion would emerge, it is doubtful whether the information gained would be worth the trouble. (While emphasis has been placed upon the impression that central office addresses of patients tend to be influenced by the addresses of financially responsible relatives, it should also be pointed out that, aside from this problem, the meaning of addresses given for elderly people is in many instances obscure, because entry into an institution sometimes coincides with the termination of residence at an address, and because some elderly people appear to have no real residences or, alternatively, to have many alternative residences.)

3.272 THE PREVALENCE OF CERTIFIED AND CERTIFIABLE CASES IN DIFFERENT AGE AND SEX GROUPS

The uncertainties regarding the allocation of people to the various census tracts do not apply to the problem of age and sex assignment. However, the assignment of cases in the mental hospitals to the six surveyed tracts is subject to the same limitations. This fact causes some uncertainty regarding the selection from the mental hospitals of the 23 cases discussed in this section.

Table 3.272-1. The Prevalence of Certified and Certifiable by Age and Sex

Age (years)	65-74		75-84		85+		Total*	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Total								
Enumerated population	198	100	505	100	97	100	1,805	100
Certified in mental hospital	14	1.17	7	1.39	1	1.03	23	1.27
Certifiable in nursing home or county home	4	0.33	8	1.58	6	6.19	18	1.00
Certifiable at home	35	2.92	31	6.14	16	16.49	82	4.54
Not interviewed	130	10.86	56	11.09	24	24.74	213	11.80
Men								
Enumerated population	540	100	235	100	36	100	815	100
Certified in mental hospital	4	0.74	3	1.28	1	2.78	8	0.98
Certifiable in nursing home or county home	2	0.37	7	2.98	2	5.56	11	1.35
Certifiable at home	16	2.96	15	6.38	8	22.22	39	4.79
Not interviewed	78	14.44	23	9.79	8	22.22	112	13.74
Women								
Enumerated population	658	100	270	100	61	100	990	100
Certified in mental hospital	10	1.52	4	1.48	0	0	15	1.52
Certifiable in nursing home or county home	2	0.30	1	0.37	4	6.56	7	0.71
Certifiable at home	19	2.89	16	5.93	8	13.11	43	4.34
Not interviewed	52	7.90	33	12.22	16	26.23	101	10.20
All cases	53	4.42	46	9.11	23	23.71	123	6.81
Men	22	4.07	25	10.64	11	30.56	58	7.12
Women	31	4.71	21	7.78	12	19.67	65	6.57

*Includes age unknown.

It is possible to examine the age and sex distribution of cases shown in Table 3.272-1 with these precautions in mind.

It shows the variation in prevalence rates of certified persons, certifiable persons in nursing homes or in the county home, and of certifiable persons at home, with age for each sex. As was pointed out previously, the numbers involved in the distribution of hospitalized certified persons are too small to justify any analysis of their variation. The number of persons in nursing homes and in the county home who were rated certifiable is not so great. However, it can be seen that community institutions play a larger role with advancing years. The large increase in the prevalence of certified plus certifiable persons after the age of 80 is only moderately reflected in the community institution cases, and, among women, is not reflected at all in the hospitalized cases.

Attention must be given to the not inconsiderable number of uninterviewed persons in each column of this table.

4. *Summary*

From a population of 1,805 over the age of 65 residing in six selected census tracts of Syracuse, N. Y., 1,592 persons were interviewed by a team of 11 trained interviewers with respect to the subjects' mental health at the time of the interview in 1952. From the information recorded by these interviewers, 100 persons were identified as having enough manifest symptoms of the psychoses of aging to be judged to be unable to care for themselves or to be a danger to themselves or others, according to the prevailing practices in implementing the provisions of the New York State law regarding involuntary certification of patients to mental hospitals. For convenience of communication, these persons are referred to as "certifiable."

The method used for gathering information, and for evaluating it, is described in some detail. A number of errors in technique, which need to be corrected, are described. The social facts and living arrangements of this particular older population are portrayed in some detail.

The distribution of certifiable cases by age, sex and socio-economic position is reported. Data relevant to comparison of rates in different types of census tracts are presented. The persons in mental hospitals with addresses of record within the surveyed census tracts were also identified. The relations between the numbers of patients (a) in mental hospitals, (b) in nursing homes and the

county home, and (c) residing at home are discussed. The relationships between severe physical disabilities and certifiability are presented. One possible source of bias in producing these relationships (the prior professional training of the interviewer) is explored.

It is concluded that the certifiable cases outside of hospitals far outnumber the certified cases in hospitals, and that there are important differences in the age and sex distributions of the two groups. It is concluded that the nursing homes and the county home play almost as large a part (numerically) in caring for certifiable persons in this age group as do the mental hospitals.

The prevalence of certifiable cases is the same in men and women. But the relationship between physical disabilities and certifiable cases is different in the two sexes between the ages of 65 and 74. It is marked in men but is much less in women. Certifiable cases among men in the age group 65-74 are found to a very large extent among those with severe physical disabilities; those among women in this age group are more evenly distributed between the physically disabled and those not physically disabled. It is suggested that the men may have had more strokes and that these are more commonly associated with certifiability in men than in women. No explanation is offered for the observation that certifiable women are more rarely reported to have severe physical disability.

Other interrelationships of these data have been analyzed and will be presented elsewhere. The following publications preceded this publication of method and basic data:

1. Bellin, S. S., and Hardt, R. H.: Mental status and mental disorders among the aged. *Am. Sociol. Rev.*, 23: 155-162, 1958.
2. Gruenberg, E. M.: Community conditions and psychoses of the aged. *Am. J. Psychiat.*, 110: 888-896, June 1954.
3. Mental Health Research Unit: Technical report. New York State Department of Mental Hygiene., 1955.

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New York State Department of Mental Hygiene
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THERAPEUTIC UTILIZATION OF MENTAL HOSPITAL INDUSTRIES*

BY LUDWIG FINK, M.D., AND EDWARD DUNNING, O.T.R.

INTRODUCTION

Hospital industry can be a useful tool in psychiatric rehabilitation, but like an old, valuable coin that has slipped from a pocket, it lies undiscovered at our front door.

The year 1956 found the Kings Park (N.Y.) State Hospital physicians enjoying the same success with the tranquilizing drugs that physicians were experiencing throughout the country.¹ The character of the state hospital ward was changing. More patients were becoming amenable to treatment and possible rehabilitation.

Growth of the open-door philosophy was altering the entire hospital milieu. New freedoms were replacing old security measures. The patients needed constructive outlets for their time and energies. They needed guidance to avoid the sterility of unproductive, wasted days.

The staff, aware of these changes, wanted to re-evaluate the total treatment approach. The term "psychoanalysisynthesis" has been suggested to describe this total effort.² The purpose here is to pinpoint *one* part of that total picture, the therapeutic use of hospital industry.

When turning to occupational therapy as a possible helpmate, the psychiatrist discovered a definite limitation. Final upgrading of a patient was to an occupational therapy center. Here production pressures do not exist. At this stage in the patient's progress, the authors agree with Faurbye who makes this observation, "In Continental psychiatry, there is a tendency to regard regular work and full working hours as the treatment whereas, in Anglo-Saxon psychiatry, there is an inclination to prefer a more hobby-like occupation."³ The writers saw assignment to one of the hospital industries as a logical, realistic step beyond the occupational therapy center.

HISTORY OF PROJECT

Kings Park State Hospital is a small community comprising an area of 830 acres on Long Island's north shore, housing between 8,000 and 9,000 patients and employing approximately 2,500 persons. There are over 100 buildings of varying sizes and the in-

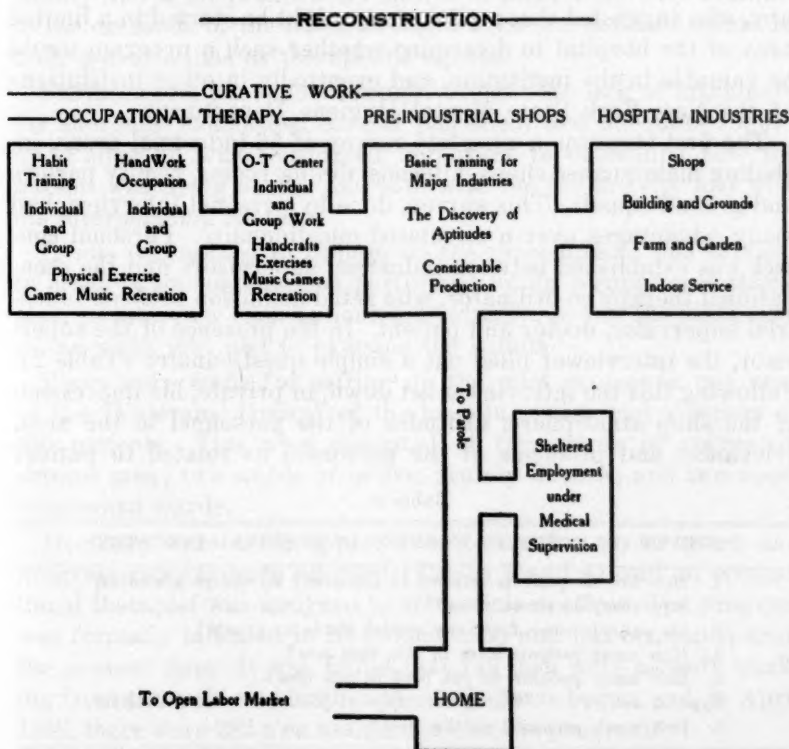
*From Kings Park State Hospital, Kings Park, N. Y.

stitution includes a modern laundry, a power plant, two greenhouses, a sewing room, a shoe shop and a dairy farm, to mention only a few of the available facilities. Opportunities for job placements abound.

The common practice in this situation was for individual doctors to assign patients to various industrial areas, but there was no organized, systematic or controlled way of doing this. True, as long ago as the 1920's, New York State had recognized the potential value of hospital industries and included this area on its flow chart of reconstruction procedures, a copy of which is represented here by Table 1. In practice this potential never became a well-devel-

Table 1. Flow Chart of Reconstruction Procedures

CHART SHOWING PATIENT RECONSTRUCTIVE WORK---STATE HOSPITAL COMMISSION
NEW YORK STATE HOSPITALS FOR THE INSANE



oped therapeutic tool, because the shortage of personnel on all levels made it impossible to institute individual programs for each patient.

Our state institutions have based their maintenance payrolls for many years on the assumption that ample, cheap patient help is available. Many hospital industries demand a constant supply of "willing workers" from the ward services. At present, there is pressure from maintenance supervisors, industrial supervisors and housekeepers for patients "well enough to work with little supervision but not yet ready to return to the community."

These were additional factors which prompted the writers to a re-examination of their hospital's industry program.

METHOD

The problem was discussed with the hospital supervisor of occupational therapy and the state director of occupational therapy, who suggested that a pilot study might be started in a limited area of the hospital to determine whether such a program would be valuable in the institution, and eventually in other institutions of the New York State Mental Hygiene Department.

The first step was a complete survey of 56 industrial areas, including maintenance shops, kitchens, dining rooms, beauty parlors and ground squads. This survey, done by personal interview, had many advantages over a circulated questionnaire. Personal contact was established between industrial supervisors and the occupational therapy co-ordinator, who acted as liaison between industrial supervisor, doctor and patient. In the presence of the supervisor, the interviewer filled out a simple questionnaire (Table 2). Following this the interviewer set down, in private, his impression of the shop atmosphere, attitudes of the personnel in the area, grievances and problems of the personnel as related to patient

Table 2.

SURVEY OF PATIENTS WORKING IN HOSPITAL INDUSTRY		
1. How are the patients referred to this area? By charge attendant, supervisor, doctor or other?		
2. Do patients come from any special wards or groups?		
3. How many patients work in this area now?		
4. How many patients do you need in this area?		
Type of Job	No. on each type of job	Job Analysis
5. How much personnel in this area?		

help, and any other pertinent information which might have been overlooked in the form. This material was compiled in a report form, with a page of statistics, observations and recommendations, and discussed with the assistant director of the hospital.

The study revealed that, at the end of August 1956, there was a total of 762 patients working in hospital industries out of a patient population of 8,950. The study also revealed that there were 948 possible job opportunities available throughout the hospital, 734 jobs for men, and 214 for women. There were, therefore, 186 vacancies where patients could work. Beyond this, the writers felt, many more jobs could be found if the employees concerned could be trained to work with mental patients.

Another conclusion of the survey concerned the industrial supervisors. While they were sympathetic and co-operative to the concept of a therapeutic program, they felt that their first responsibility was to the production required of them. They were oriented to the demands of the business administration, and less aware of their potentialities as therapeutic agents.

Furthermore, the report brought to light the lack of machinery for thorough evaluation, careful placement and adequate follow-up. Follow-up was considered important to determine how the patient was doing on the job, both with the job activity and with his interpersonal contacts.

It was determined to tighten up the procedure in this service; to create a liaison function performed by an occupational therapist; to interview each patient individually; to put the right man in the right job; and to examine the results.

Plans were made for setting up the pilot project in one area of the "Veterans' Group" of the hospital which had a census of 650 patients. This area consisted of two wards of regressed, chronic men; two wards of active, acutely ill men; and two open, honor-card wards.

Meetings were held, appropriate forms for prescription and progress reports were adopted (Tables 3 and 4) and an occupational therapist was assigned to act as liaison officer. The program was formally initiated in November 1956 and has continued until the present time. It was found that 148 men were already working from these six wards when the project was begun, and, in April 1959, there were 282 men assigned under the program.

Table 3.

INDUSTRIAL THERAPY PRESCRIPTION*		
Name	Date	Ward.....
Former Industrial Placement		
Assigned to: Department		
Age	Marital Status	Occupation
Precautions:		
Physical Disabilities:		
Remarks:		
Assigned by.....		M.D.
		O.T.
Placement made by.....		
The patient has been delivered to me and instruction given as to individual differences.		
		Industrial Therapist
Date Discontinued		
Reason		

*From Am. J. Occ. Ther. V:1, 19, 1951.

Because of the multiplicity of factors, it is difficult to determine the direct results of the program statistically. It would be impossible to say, for example, how many men went out on convalescent care, or how many received honor cards as a direct result of the program. It can be indicated that 519 men were interviewed in this period for purposes of industrial placement, that 326 were actually placed in working assignments and that 269 were followed up or had adjustments made in their assignments.

Two brief case histories may help illustrate the value of this tighter control. There were many examples to choose from. The two described here must stand for many others who were similarly helped.

Table 4.

**KINGS PARK STATE HOSPITAL
MONTHLY WORK THERAPY REPORT***

NameWardDate

Job Assignment TitleNo.

Date Patient AssignedThis is a.....routine report
.....special

Attendance	Cooperation	Work Quality	If this is a special report state reason
Regular	Excellent	Excellent	
Irregular	Average	Average	
	Poor	Poor	

Remarks:

Signed.....

Report reviewed by

Report reviewed byM.D.

*From Northville State Hospital, Northville, Mich.; director, Gordon R. Forrer, M.D.

CASE HISTORIES*Case A*

A was born in 1895 in Turkey; he entered the United States in 1912. He was admitted to Kings Park State Hospital in 1932 with the diagnosis of schizophrenia, paranoid type.

The clinical notes in earlier years reveal assaultive behavior towards staff members and other patients. Later descriptions (1951) show him as "quite deteriorated, delusional, seclusive, withdrawn; leads a vegetative life." The phrase which consistently appears in each note from 1932-1957 is "idle on the ward."

In August 1957, A was interviewed and evaluated for industrial placement. Because of his trade, shoemaker, and despite delusions about wanting to hire the staff members as salesmen for his shoes, he was placed in the shoe shop.

By October 1957, he already showed improvement, with ability to answer questions to the point. He was recommended for an honor card. He was not on medication when he was placed, and has no medication at present.

In April 1958 he was described as follows: "Patient is in good contact and oriented. He is content and well-institutionalized. He is a good worker in the shoe repair shop. Patient is considered co-operative, sociable, clean and tidy."

As of April 1959, this man lives on an open-ward, enjoys honor card privileges and works regularly in the shoe repair shop. His delusions persist.

The writers feel that he has been successfully upgraded from his former existence and enjoys a fuller life within the limits of his illness.

Case B

B was born in New York City in 1919. He completed two years of college. He was admitted to the hospital in 1955 with a diagnosis of schizophrenia, paranoid type.

His subsequent course reveals him becoming "more paranoid, evasive, suspicious, hostile; refusing to work without payment; difficult to manage on the ward; losing weight and becoming anemic."

In May 1958, he was placed on thorazine spansules, 300 mg. t.i.d.; an honor card was granted; he was started in group therapy; he was stimulated to activity in patient self-government and he was assigned to work in the TV repair shop.

When he was interviewed in September 1958, he expressed his desire to obtain a certificate as a TV repairman if he were released. In November, he said he felt fine, had been studying, enjoyed his position in the TV shop, and had investigated job possibilities when on home visit.

In January 1959, B was placed on convalescent care and started reporting to the aftercare clinic.

In March 1959, the aftercare note indicated the patient had been working regularly at an electronics firm since his release, had been making a fairly good adjustment, and wanted to return to school to complete requirements for his engineering degree.

A direct relationship is seen between his hospital activity and his present job interest. His industrial assignment is viewed as one contributing factor in the total treatment plan.

DISCUSSION

During the course of this project, problems have arisen. Should referrals of patients for work assignments be accepted from all sources, including the industrial supervisors, ward charges, attendants, nursing supervisors and patients themselves? The writers have found that such acceptance does work satisfactorily, and that it seems to enlist the interests of all groups in a common cause. Such referrals are evaluated by the physician and the occupational therapy co-ordinator, and assignment comes from the physician.

A second consideration is the question of legal responsibility in case of accident to a patient. While all reasonable precautions are taken by the physician in the original assignment, and by the industrial supervisor on the job, still the possibility of injury exists. It has been found that some industrial supervisors are reluctant to accept patient-assignees for fear the supervisors may be held legally and financially liable in case of accident. This fear can be dispelled by pointing out that the hospital authorities assume this responsibility as a calculated risk in a therapeutic program.

The industrial supervisor, responding to the concept of himself as a producer of goods, often resents losing a patient who has been upgraded to a better job. This points to the need for further education and orientation of nonmedical personnel to therapeutic goals.

The writers were plagued for some time by the lack of attendants to accompany non-honor-card patients to the industrial areas. This has been resolved by growth of the open-door concept.

The active participation of a clinical psychologist, a senior social worker and a representative from the New York State Office of Vocational Rehabilitation gave depth and direction to the total treatment planning.

The writers have felt that, as part of a therapeutic program, a minimum "wage" should be paid monthly to each working patient. This would simulate a more real job situation with the concomitant responsibility of handling money. Money is a recognized, positive, cultural incentive. If a grading system of payment, according to work performed, could be implemented, effort would have its reward. This has not been possible to date.

Another unsolved problem is the need for more physicians. Placement in a working assignment should not be an end in itself, but a step toward the patient's rehabilitation. Supportive therapy should be available to men starting in a new activity, at least in the form of group sessions. Close attention to the patient's needs and an adequate follow-up should be provided. Too often, placement turns out to be an end in itself—where a patient succeeds at a task and remains doing it, or, in the event of failure, returns to the idleness of the ward. More physicians would allow better handling of such situations.

The lack of occupational therapists to perform the liaison function has prevented the writers from extending the program beyond the boundaries of one service. At least one other hospital⁴ has successfully used a skillful attendant in this capacity.

FUTURE PLANS

Some of the problems in establishing a successful program have been discussed. Hospital industries, however, form only one step in the continuum from sickness to eventual adjustment in the community. Logical growth suggests further steps to be taken.

The writers are interested in the development of a vocational and general educational training program. This would involve facilities and instructors for auto mechanics, watchmaking, metal-working, mechanical drawing and blueprint reading, lens grinding, lathe and machinery operation, sewing machine operation and garment industry techniques, shorthand, typing, bookkeeping, operating business machines, clerical work and languages. Courses and examinations could be set up leading to the high school equivalency diploma. This would provide positive goals for the patient and prevent the feeling that time spent in the mental hospital is wasted time. This concept is a reality in hospitals of the Veterans Administration, where these activities are handled by departments called manual arts therapy and educational therapy.

A second area under consideration is a member-employee plan which has proved successful in the Veterans Administration. The present concept originated about 10 years ago with Dr. Peter A. Peffer who was then manager at the Veterans Administration Hospital, Perry Point, Md.⁵ Basically, it means that a patient can become a hospital employee for a maximum of one year at one-third pay. He lives in employee quarters on the grounds and

enjoys the benefits, status and responsibilities of a regular employee. M-E items are rehabilitation positions, which do not affect the staffing patterns or the ratio of regular employee items. A detailed plan has been worked out by the staff of Kings Park State Hospital and submitted to the New York State Department of Mental Hygiene, where it is under consideration.

The concept of the night hospital offers a third avenue for future growth. Kings Park patients often have difficulty in relocating in the community because they cannot make satisfactory residence arrangements. It would certainly be possible for patients to work in the community and return each evening to the hospital. Progress has been hampered to date by Kings Park's rural location and the lack of adequate transportation to and from the hospital.

A fourth development which is being watched with interest is the extension of the sheltered workshop concept to the public mental hospital.*

REVIEW

Objectives of a hospital industries program.

A. Therapeutic placement (patient centered) is the primary goal. At present, the use of patients in hospital industry is too often hospital centered (get the work done). A well-run hospital industries program could satisfy both goals. This would involve:

1. Careful evaluation of the patient by the physician and co-ordinator before assignment. Assignment is then handled by prescription, like any other treatment procedure. (See Table 3.)
2. Systematic follow-up to determine how patient is adjusting to the activity, the supervisor and other patients in the area. Monthly conferences of all persons involved, in which the patient's progress is evaluated and future plans formulated. This should include upgrading from less responsible, less difficult jobs to more responsible, more difficult jobs.

B. Therapeutic utilization of hospital industries should be viewed as one link in the rehabilitation continuum, which begins at the reception service and ends with the person

once more in the community. The program for a patient might look something like this:

1. Patient enters reception service.
2. Diagnostic conference with individual treatment planning.
3. Ward activity program.
4. Somatic-psychiatric treatment.
5. Recreational and socializing activities.
6. Occupational therapy center program.
7. Therapeutic utilization of hospital industries.
8. Vocational training for appropriate persons.
9. Member-employee program.
10. Night hospital.
11. Sheltered workshop within hospital.
12. Preparation by social worker and rehabilitation counselor for release.
13. Patient returns to community.
14. Follow-up by aftercare clinic.

SUMMARY

New strides in the treatment of mental illness require adjustments in state hospital rehabilitation measures. The hospital industry program has been re-evaluated and re-organized in one service of a large state hospital. The program has proved to be a sound and valuable treatment procedure. Two case histories help illustrate this point. Some of the problems encountered have been discussed. Forms have been included to help clarify the text. Future plans have been briefly presented.

ACKNOWLEDGMENT

The success of this program is a team success. Many people, on all levels, administrative and staff, have contributed. The authors are grateful for the co-operation which has resulted in improved treatment of patients. Special thanks are due to Charles Buckman, M.D. director of Kings Park State Hospital; George Volow, M.D., assistant director, and Mrs. Viola McGrath, former supervisor of occupational therapy, now director of Occupational

Therapy Services, New York State Department of Mental Hygiene.

Dannemora State Hospital
Dannemora, N. Y.

and
Rochester State Hospital
Rochester, N. Y.

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RESEARCH AND THE OVERTAXED MENTAL HEALTH CLINIC*

BY GORDON E. RADER, Ph.D.

The problem of the overflowing of our mental health clinics by excessive demands for service is so universal as to be almost too trite to mention. Many clinics throughout the country report waiting lists exceeding a year. Certainly the situation in the majority of clinics has been desperate for some time. Those who are on their staffs are probably working at or near the limits of their endurance. It must seem strange then, perhaps even ridiculous, to talk about initiating research in such clinics. Nevertheless, this is what this paper will urge.

The writer must admit that it was difficult to decide just what to say here. One of the problems was this: For a psychologist, the word "research" sets off a very particular response. Inside the psychologist's head the voices of former professors are heard shouting in unison, "Be rigorous, be rigorous. Design carefully. Watch your controls. Be rigorous!" But then, one thinks of the problem at hand. The overworked staffs are struggling to keep up—or should one say "catch up"—to the excessive demands for service plaguing all our clinics. Who will listen to any suggestions to add to that burden the time and effort usually required to develop a carefully designed, rigorous study? So, the narrow definition of research will be dropped, at least for the moment, and there will be an attempt at a few words that may be of some practical use.

Temporarily, the writer would like to expand the word "research" to include a spirit of innovation, a willingness to look for and try out new approaches, new procedures, perhaps even revolutionary attempts to solve the problem. Now this is hard. The natural reaction to the pressure of excessive demands is to stop thinking (thinking takes time, after all) and to fall back on those ways of handling the problem which are most familiar and automatic. And this is the danger. The more the pressure mounts, the more one tends to get in a rut and not search for a solution. This tendency to stagnate must be actively fought. One must force one's self to look for new and unfamiliar ways to handle these

*This paper is from the North Carolina Memorial Hospital, University of North Carolina. It is based on a paper presented at the annual meeting of the Association of Mental Health Clinics in North Carolina, November 14, 1958.

service demands. It has been frequently pointed out that progress in all fields of human endeavor does not depend so much upon the refinement and perfection of existing ways of doing something as it does upon the discovery of some entirely new technique or tool. After all, the fastest sailing vessel will never overtake the steamboat, nor the brightest candle outshine the electric light.

Not so very long ago, the writer read of a child guidance clinic in Florida whose waiting list had been growing steadily longer.* Finally, it came to the point where the staff members were having to tell the parents that it would be nearly a year before they would even be able to see a family for an evaluation. Obviously something had to be done. The staff had a series of meetings and agreed at the start that no streamlining of current procedures would meet the situation. As a result of these meetings, it was decided to try out two entirely new approaches: one at the evaluation level and one at the therapeutic level of the clinic's functions.

It was agreed that the first and most urgent need was to develop some kind of approach that would make it possible for patients to be seen for an initial interview without delay—without a waiting list and without a waiting period. Such an interview would then come when the patient's need was most acute and would provide some support and give some hope, even if it did not give definite help. A new system was initiated.** Under this procedure, the parents of each new child patient are scheduled to come to the next weekly "screening group." This screening group is a one-hour meeting of new parents with a psychologist and psychiatric social worker. The group sits at a round table and each parent in turn explains his problem in an atmosphere where the other parents are free to comment as they wish. At the end of the session, the social worker and the psychologist compare notes and reach a decision on recommendations. Even where it is felt that one or both parents or the child should be seen individually, the parents have already established some relationship with the clinic and are more relaxed and productive at the next contact. Following the new procedure, there was a substantial decrease in broken appointments for intake. Also the parents frequently received some support, and reduction in anxiety and guilt, from each other, simply

*Ginott, H. G.: Group screening of parents in a child guidance setting. *Int. J. Group Psychother.*, 6:405-409, 1956.

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**Described in the *Int. J. Group. Psychother. paper*.

through realizing that others have similar problems with their children. They could thus more easily tolerate some delay before their next contact.

For many of the families, it was found that the second innovation in the clinic's function—the one at the treatment level—often proved to be a satisfactory and sufficient solution.* Certain parents selected on the basis of the group screening were enrolled in a "parent education group" which consisted of 20 to 25 mothers meeting weekly for 90 minutes over a period of 10 weeks. There were separate groups for mothers of preschool, school-age, and adolescent children. Those who were referred to the group were mothers who basically liked their children, but who had difficulty in getting along with them because of ignorance, faulty expectations or confused cultural and social standards. In the group, the mothers were first encouraged to explain their complaints and their attempted solutions. Mothers who felt they were not strict enough met mothers who felt they were too strict. At first this made all of them feel confused and hopeless. However, the group leader helped them to see feelings as the cause of actions and to see the necessity of changing or channeling these feelings, rather than merely disciplining the child's actions. As they became more accepting of their children's negative feelings and more cognizant of the impact of their own subtle attitudes and actions on their children's feelings and conduct, they were also introduced to many specific techniques to handle certain situations. These groups, of course, produced no basic personality changes, but they did produce considerable change in attitude and understanding, which was probably reflected in the handling of the children. Parents found this helpful and satisfying, and where actual psychotherapy was needed, these groups often proved to be good preparation. On the basis of their experience, the staff of this Florida clinic felt well satisfied with the results of this little experiment with new procedures.

The experiences of this Florida clinic are not cited because there is any feeling that they have developed something new or have some sort of final answer here. Rather, it was hoped to illustrate the necessity and possible value of actively considering new solutions, even though one's energy, initiative and enthusiasm for venturing into strange and unfamiliar territory seems to *decline*

*See Ginott's Ment. Hyg. report.

in a ratio of geometric progression to the *increase* in the need for some new approach.

Earlier in this paper, it was suggested that the more formal, rigorously designed type of research was not particularly practical in a clinic already overburdened by excessive service demands. Now, the writer will flatly contradict himself and say that this need not be so. With a little thought and ingenuity, some very fine research studies can be carried out with practically no disruption of the service functions of a clinic. A tremendous amount of data is constantly being gathered and recorded in every psychiatric facility. Research is nothing more than organizing various data in such a way that meaningful comparisons can be made between one part of the data and another. Very elaborate measures for gathering and comparing data may be evolved for a particular project but in the end it still amounts to the same thing: One organizes some data into appropriate patterns and then compares one bit of the data with another bit. Why not do the same with some of the data constantly pouring into the clinic?

One may say that sounds easy until one tries to do it. The writer would have to agree. However, he feels that this is a problem for which there is a solution—or at least a partial solution. One of the major difficulties, as he sees it, lies in the traditional record-keeping policies of most clinics. At present almost all clinics produce and file reports written by various team members concerning their contacts with the patient or his relatives. Reports of initial contacts and impressions, closing summaries, interim reports, and various other sorts of data are likely to find their way into the chart. These reports are descriptive and will vary tremendously on the basis of the personal interests, theoretical orientation, temperament, temporary state of mind, compulsiveness, available time, and so forth, of the person writing the report.

It is next to impossible to track down and extract from such reports meaningful data which are comparable from patient to patient on even such crucially relevant clinical material as degree of pathology, intensity of discomfort, or psychotherapeutic prognosis. Yet there is no reason why formalized schemes for recording data in a standard form cannot be developed and made a part of routine clinical procedure. It takes no more time—in fact it takes less—to put a check mark in the appropriate box or along a scale to classify or rate prognostic opinion at the time of evalua-

tion than it does to put down one's prognostic opinion in words. So, too, check marks are the easier way to indicate one's opinion as to the results of treatment in the closing statement. Here, then, conveniently at hand, one could have the data for a study of the validity of prognostic estimates. No one would have been put to any trouble, because the data would be obtained and go into the records in any case, though in a far less precise and useful form. The writer's proposal, then, is that procedures be effected for the organized and systematic recording of data which are relevant to the service functions of the clinical and therefore would usually be recorded in some manner anyway. This involves the creation of special forms of one sort or another.

Now, most people have an immediate strong negative reaction to forms, the more elaborate the forms, the stronger their reaction. One may complain that forms take too much time. This might be true if they are not substitutes for some of the customary report writing. However, the writer sees no reason to repeat in writing what has been adequately expressed on a form. This raises another common objection: If you reduce a patient to a bunch of marks on a form, you've destroyed his individuality; you must fail to capture the subtleties of his personality and functioning. This does not seem a valid objection, since any form can be made to provide space for descriptive elaboration and still record far more data in less time (and probably with less secretarial effort as well) than written reports. One can strike any balance desired between free description and classification within a predetermined system. Even the organization and standardization of descriptive material, so that certain areas or topics are routinely discussed, can be of great research advantage. In addition to these obvious research advantages, such formalized procedures may add to the effectiveness of the service functions, as one is forced to think in a concrete, specific, and organized fashion about the patient with whom one is dealing.

To return to the problem of overtaxed mental health clinics, where can research efforts be directed at the solution of this problem? If one thinks of the flow of clinic functions extending between the initial and final contacts of the patient with the clinic, one can roughly separate the following stages: (1) Evaluation procedures—gathering the initial data. (2) Synthesizing and reporting the

evaluation data. (3) Dispositional decision. (4) Treatment. (5) Termination.

One may look at each of these stages in turn and consider a few of the ways in which research (broadly or narrowly defined as the case may be) might contribute.

The evaluation is essentially a period of data-gathering by the various members of the clinic team. The goal is to obtain the maximum amount of information with the least expenditure of professional time. Since to some extent these two aims are antithetical, one very important research question would seem to be how much of what sorts of information are required in order to make any necessary dispositional decisions. Any time spent gathering additional information might well be wasted, if this information were not needed in subsequent dealings with the patient. For example, a thorough inquiry into the patient's early life experiences seems unnecessary if he is simply to be put on medication and sent home, or is to be referred to another agency. Too frequently, obtaining a comprehensive picture of the patient has become a goal in itself. Perhaps what is needed is a system whereby patients are evaluated in steps. At each step, the minimal information would be obtained to allow one to screen out a certain number of patients and decide upon their disposition. To set up such a system, it is essential to know what the various decision possibilities are and just what information is required to reach those decisions. This would seem to be a problem for research.

Once it is decided what information is useful, then one must search for the most economical ways of obtaining this information. Group interviewing is being tried in a number of clinics such as the one mentioned in Florida. Studies are urgently needed to evaluate the comparative yield of group and individual diagnostic interviews. In addition, it might be fruitful to consider methods of using the patients' time to save professional time. For example, much background information could be supplied by the patient himself in filling out printed information sheets, perhaps with the help of a receptionist or secretary. This would relieve the psychiatrist or social worker of this task and allow him to concentrate directly on gathering information which requires professional skill. Allowing the patient to record his own data is the principle behind group psychological tests. Ingenuity and research are needed to develop tests or techniques of this sort—

techniques which require relatively little examiner-time and yet do not sacrifice the depth and flexibility of the better individual projective techniques.

The second stage, synthesizing and reporting the evaluation data, may not seem an area for research or for the trying of new procedures. However, the writer has already made two suggestions that are relevant here. First, the development of forms for recording data may increase the speed and efficiency of organizing and reporting findings. Second, research on the most useful data for making decisions may be pertinent to the optimum length and content of reports. The writer suspects that many records lose their effectiveness because useful information is buried in much nonessential information.

This brings matters to the point of making some decision about a course of action with the patient. If the clinic has greater demands for service than it can handle, some selection of patients for treatment will necessarily take place. Even if an open-door policy is in effect and all seeking help are put on a treatment waiting list, a form of selection is involved. A patient is chosen because his name appears at the top of a list at the expense of someone who may need help now but must defer to the waiting list. While in one sense this is very fair, it does not necessarily dispense service either where it is most needed or where it will do the most good. If the policies of the clinic allow keeping the latter goals in sight, there is great need for research which will help to select patients who will stay in treatment long enough to benefit, to select patients with good prognoses, and to identify external situational variables which preclude progress and make treatment a waste of time, or at least a misdirection of effort. Much good research is already being done, especially on premature termination and prognosis.

Next in line for consideration is the very large and complex area of treatment. The needs for research and new ideas in this area are well-recognized. The immense expenditure of time required to treat emotional disturbances, especially with standard psychotherapeutic methods, makes this the main bottleneck responsible for everextending waiting lists. Therefore, any therapeutic measures calculated to reduce the time of standard therapeutic

methods, and capable of dealing with large numbers of patients simultaneously, warrant attention. Increasing consideration is being given throughout the country to various forms of group psychotherapy. Research is much needed on the effectiveness of, and indications for, various group psychotherapeutic approaches. Since intensive individual psychotherapy cannot begin to meet the treatment demands of most clinics, careful consideration must be given to more limited treatment programs, accepting more limited goals if necessary. Parent-education groups are one alternative that has already been mentioned. Another might be the limitation of treatment to just one key member of the family, for example, the mother. Not too much is yet known about the extent to which one can "treat" one member of a family through another family member. This proposal would, of course, be most applicable in handling problems with children. Other devices to speed therapy are being tried here and there (hypnoanalysis, the use of various drugs such as sodium amytal, psychodrama, special assigned reading, other educative efforts, etc.). Most of these are adjuncts to, rather than replacements for, standard psychotherapy. Ingenuity and freedom to develop and try out new approaches should be encouraged.

The final action that must be taken with regard to a patient is termination of treatment. Research on the optimum point of termination could be fruitful. It may be desirable to set very limited goals and terminate treatment when these have been achieved or, on the other hand, to study factors which relate to rate of progress and terminate treatment at the point of diminishing returns, where the time spent could be utilized better to help somebody who would show a faster improvement rate. All of these possibilities seem dependent upon adequately measuring therapeutic change, a problem which has not been satisfactorily solved as yet. The search for such measures is an important research goal in itself.

In this paper, a few rather random observations and suggestions, regarding research and the problem currently facing our clinics, of having more requests for service than they can handle, have been offered. Professional stagnation and inflexibility of procedure are among possible outcomes of such pressure. It seems essential

to avoid such dangerous outcomes and to develop some active service-oriented research interests—or, at the least, an “experimental attitude.”

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PATIENTS' ATTITUDES TOWARD SOCIO THERAPY*

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As psychiatric thinking is moving toward a broader understanding of human behavior in relation to the cultural environment, much interest has been shown in the mental hospital as a small society. This approach has emphasized the importance of staff expectancy in influencing the behavioral patterns of patients and, consequently, has resulted in attempts to change these patterns of adjustment through new developments in ward management, such as patient government¹⁻³ and the therapeutic community.⁴⁻⁸

However, only a very few investigations have been made of the patients' attitudes toward these developments in sociotherapy. In one of these, Joan Thurston⁹ interviewed patients about their attitudes toward patient government.

Because the authors believe that knowledge of the patients' attitudes toward these procedures would be helpful in evaluating their effectiveness, a questionnaire was given to the ward population of an acute treatment ward at a large state hospital located near a metropolitan area. By analyzing the information thereby obtained, it was hoped to determine what elements of the ward program the patients considered helpful and to understand how they perceived the hospital and ward atmosphere.

THE WARD AND ITS PROGRAM

For 10 months before the administration of this questionnaire, the therapeutic emphasis was placed on ward meetings, attended by all patients. Two weekly patient government meetings, presided over by the elected officers, facilitated the assumption of patient responsibility for fulfilling ward duties, planning activities, and resolving interpersonal conflicts.

Every Thursday, a community therapy meeting was conducted by the ward doctor (V. Fryling), or other members of the ward staff. Problems of community living, as well as those of a personal nature, were discussed in these meetings, with the primary emphasis on the free expression of feelings. After this program had been established for four and a half months, an additional once-weekly community meeting was arranged with a consultant

*The writers wish to express their deep appreciation to the administration and the staff members of Mendocino and Agnews (Calif.) state hospitals for this report.

from Stanford University Medical School, Dr. Harry A. Wilmer,¹⁰⁻¹² as the group leader. This session constituted part of the hospital's educational program designed to give about 20 members of various professional groups the opportunity to observe and participate in a therapeutic community demonstration.

The acute and intensive treatment ward where the inquiry was conducted housed an average of 75 women patients, with a mean age of 35.5 years. During the period of this study, the median time spent in the hospital by the patients was 88 days; and of those, 79 days had been spent on this ward. Eight patients a month were transferred to other wards for medical treatment or for closer supervision in cases of severe behavioral disturbances, and about 20 patients were discharged each month. All except three or four patients at any one time had had ground privileges until the ward had been made an open ward during the month preceding the questionnaire.

About 40 per cent of the patients were voluntary; the others were committed as mentally ill. The distribution of psychiatric diagnoses, as given in the tabulation, varied little during the period of the study.

At any given time, about 20 patients were on tranquilizing drugs and four on EST, twice weekly. A total of 20 patients had received an average of 11 electric shock treatments during the past year. About 10 patients participated in small group therapy sessions, conducted by the social worker, 20 attended occupational therapy, and 45 had industrial assignments, working approximately four hours daily in addition to their other therapies. Eight to 15 patients participated in the educational program conducted by volunteers. The main emphasis was placed on group processes, in the verbal as well as in the activity therapies, and the large ward meetings were utilized to increase the communication channels between the staff and the patients.

Diagnostic Category	Per cent
Schizophrenic reaction	56.2
Manic-depressive psychosis	4.1
Involitional depression	15.1
Psychotic depression	9.6
Neurotic reactions	6.8
Still undiagnosed	8.2
	100.0

THE QUESTIONNAIRE

To gain insight into the patients' view of this sociotherapy program, a questionnaire was developed, consisting of very general, open-ended questions designed to obtain unstructured responses from the patients about various aspects of the ward program. It was administered, at the same time, to all the patients on the ward, by a psychologist who was not a member of the ward team. The patients were encouraged to give frank expressions of their opinions, both favorable and unfavorable, without giving their names. It was stressed that their comments would be of great help in evaluating the treatment program and in planning for improvement. The responses to the questions were rated as to degree of positiveness, and the various items and reasons mentioned in the answers were scored by categories in a crude form of content analysis.

The patients were informed of the general outcome of the questionnaire, and the main criticisms and specific proposals for improvement were transmitted to the patient government for further consideration. The patients reacted very favorably to having had the questionnaire, were pleased that their opinions were meaningful to the staff, and wondered whether similar studies have been done before.

Greenblatt¹³ reports a similarly favorable response by the patients at Boston Psychopathic Hospital toward being interviewed about opinions concerning the hospital program and their suggestions for improvement. From this favorable reaction, patient government developed at that hospital. The writers, through this study, hope to illustrate the usefulness of questionnaires or interviews inquiring into patients' attitudes, as techniques in helping to develop a closer understanding between patients and staff.

Six areas of the patients' hospital experience were investigated by means of this questionnaire and will be reported on in this paper. In Area I, questions 1 and 2 inquired about what the patients liked and did not like about the ward and the way it was run, and asked for suggestions for improvement. The second area, questions 3 and 4, dealt with the evaluation and criticism of ward government. The next two areas, consisting of one question each, inquired how the patient felt about the Tuesday meeting conducted by Dr. Wilmer and the Thursday meeting conducted by the ward doctor, and what they found personally helpful in

these meetings. Under Area V, it was asked in two questions what the patients found most helpful in the total hospital program, what aspects of the program were not satisfactory, and what suggestions they had for improvement. In the last question, in Area VI, the patient was to give an evaluation of her stay at the hospital in terms of benefits to herself and the solving of her problems.

At the time of the study the ward population was 63; of these only 56 took the questionnaire. Two who participated in the survey did not answer any of the questions, and six others answered only one or two questions. Thus, only 48 out of the ward population of 63 (or 75 per cent) co-operated in any effective way in answering the questionnaire. As the patients were not required to sign, it was impossible to determine if these non-co-operators were the most disturbed, depressed, or hostile patients.

The results of the questionnaire will be reported in terms of all 56 of the surveys which were returned, even though some of these did not express anything. The authors felt that it was most reasonable to assume that these non-co-operators resulted from negative attitudes toward the ward; consequently their returns will be so treated.

RESULTS OF QUESTIONNAIRE: FAILURE TO REPLY

While only 17 answered all nine questions, 32 replied to seven questions or more. The tabulation shows the number not answering each question:

	No. not answering
Area I, q. 1 Evaluation of ward: positive question	8
q. 2 Evaluation of ward: negative question	16
Area II, q. 3 Evaluation of patient government: positive question ...	16
q. 4 Evaluation of patient government: negative question ..	26
Area III, q. 5 Evaluation of Dr. Wilmer's meeting	16
Area IV, q. 6 Evaluation of Thursday ward meeting	19
Area V, q. 7 Evaluation of hospital program: positive question ...	23
q. 8 Evaluation of hospital program: negative question	30
Area VI, q. 9 Evaluation of benefits of hospitalization	11

Where a positive and a negative question were asked about the same subject, fewer answered the negative question than the corresponding positive one. While this might indicate a general reluctance about expressing negative feelings, there is evidence that

other factors may also be contributory. There was only one person who consistently did not answer the three negative questions, while answering all the corresponding positive ones. Furthermore, the respondents may not have had any readily available criticism or suggestions for improvement. This is indirectly supported by 18 replies to the negative questions, stating merely "no suggestions" or "no criticism." Further, as will be seen later, the positive responses showed much more agreement than did the negative responses, a fact seeming to indicate that group norms were more developed for favorable opinions, making it easier for the patient to express herself favorably.

Except for the last question, the questions toward the end of the questionnaire were not answered as often as those at the beginning. This may have resulted from a large number of patients losing interest in the questionnaire. On the other hand, these results could well be interpreted as indicating that the patients were most willing, or able, to discuss the ward and their own selves and least willing to discuss the hospital program.

To formulate an explanation for this lack of response, the incidence of unanswered questions was analyzed from another point of view. Each patient had been asked to indicate on the questionnaire how long she had been on the ward. Forty-three patients cooperated by doing so. From this information, it was possible to calculate the percentage of patients with various lengths of stay on the ward who did not answer the questions.

The analysis showed that those who had been on the ward a short time tended to answer many fewer questions than those who had been there longer. For example, the six persons who had been on the ward less than a week answered only 15 per cent of the questions, while the six who had been on the ward more than a year answered 94 per cent. These figures show that a certain amount of time is necessary before a new patient can or will express opinions. This appears to represent the time required for integration of the patient into the ward program. After this period, there is a sharp decrease in failure to respond.

The time of integration was shortest, about one week, for the first question, asking for an opinion about the ward and longest, about three months, for the questions about the hospital program. After a month on the ward, the patients were able to communicate their impressions of the therapeutic community meetings. In

general, the time of integration was not so sharply demarcated for the questions about ward government and for the negative questions.

Those, however, who did not indicate the time they had spent on the ward answered the questions toward the end of the questionnaire less often than those at the beginning and evidently were inclined not to complete the questionnaire. Thus, it would appear that several factors were involved in failure to reply: General rejection of the entire questionnaire, lack of integration into the various aspects of the ward program, tiring, lack of formulation of criticisms, and inability to comprehend or think abstractly. This last factor might have been expected to be a considerably greater hindrance than it was, for the applicability of a questionnaire in assessing attitudes of patients of varied educational levels and with a predominance of schizophrenic illness.

RESULTS OF QUESTIONNAIRE: POSITIVENESS OF ATTITUDE

The patients' responses to the questionnaire were next analyzed as to their degree of positiveness, as inferred from the content of the answers. They were adjudged as generally positive, generally negative, or neutral, as shown in Table 1. Where both a positive and a negative question were asked regarding one area, the questions were scored together. The form of the question seemed to make little difference as to the degree of positiveness shown.

Table 1. Positiveness of Attitudes Toward Various Areas of Hospital Life.
Results given as percentages of all 56 questionnaires

Nature of general attitude	Area I The Ward Ques. 1 & 2	Area II Patient Government Ques. 3 & 4	Area III Tuesday Meeting Ques. 5	Area IV Thursday Meeting Ques. 6	Area V Hospital Program Ques. 7 & 8	Area VI Benefits of Hospitalization Ques. 9
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent
Positive	68	61	64	39	37	59
Neutral	11	4	2	7	16	7
Negative	9	9	5	20	4	10
No response	9	21	29	34	41	20
Irrelevant responses	3	5	0	0	2	4
Total	100	100	100	100	100	100

In fact, the most negative response occurred on the question about the ward doctor's community meeting, which did not specifically ask for a negative evaluation. To test the reliability of these judgments, the answers were scored separately by each of the authors, three months apart, with 96 per cent agreement.

The attitudes toward the ward, patient government, the consultant's Tuesday meeting, and the benefits of hospitalization were predominantly positive, whereas the Thursday community meeting and the hospital program were viewed much less positively. In the case of the Thursday meeting, this resulted from the greater number of patients who expressed open criticism; whereas, in the questions regarding the hospital program, there was an increased reluctance to respond.

The more favorable response to Dr. Wilmer's meeting—as compared to the ward doctor's meetings—may partly be a result of his being viewed solely as a therapist, whereas the ward doctor also had administrative responsibilities for the patients. Those who had participated in the ward doctor's meetings before the start of the Tuesday demonstrations saw the Thursday meetings in a more ward-oriented light and, therefore, reacted more favorably to them than did the newcomers.

An interesting sidelight was brought out by another question, not otherwise reported in this article. Thirty-three, or 59 per cent, of the patients responded with favorable comments about the ward doctor, while only 6 or 11 per cent, expressed negative sentiments. Of the 16 persons who were positive toward the Tuesday, but negative or neutral toward the Thursday, meeting, seven expressed positive and only two negative feelings toward the ward doctor. Thus, the patients were able to distinguish between their attitudes toward the ward doctor and toward her meeting.

To the writers' surprise, no objections were raised to the presence of numerous visiting staff members who for the most part were strangers to the group. Instead the patients interpreted their attendance as indicating a special interest in their meeting.

RESULTS OF THE QUESTIONNAIRE: ITEM ANALYSIS

In studying the content of the replies, the answer to each set of questions was divided into separate items. Thus, for example, the following answer to the first question, regarding the ward, "I like the ward government and the friendly atmosphere," would

be composed of two items, (1) "liking ward government" and (2) "liking the friendly atmosphere." Each item mentioned in a given answer is considered to be a response. Thus as the terms will be used, an "item" will refer to the particular concept or feeling, while mentioning an item in a given answer is a "response." Thus, if three persons express liking for the patient-staff co-operation, there would be three responses to the item "patient-staff relations." The separate items were next combined into five categories based upon their orientation. These categories are designated as (1) group attitudes and social atmosphere; (2) activities provided by ward and hospital; (3) physical surroundings of ward and hospital; (4) the hospital and ward program and its administration; and (5) individually-oriented gains and losses. For clarity, it is essential to define each of these more carefully, and show what types of items were included in each of the various areas.

The first category, group attitudes and social atmosphere, includes items which mention the attitudes prevailing on the ward, in the hospital generally, or within the particular meeting under inquiry. Also included, would be items which see various parts of the program as helping to create certain group or ward attitudes, and items which relate the benefits of ward government or the community meetings to other persons besides the respondent. Some of the items included in this category are: Co-operation of staff and patients, friendliness of the ward, promotion of greater freedom of speech, benefit of the meetings to others in solving their problems, lack of unity, and critical attitudes toward technicians.

The second category includes items related to ward or hospital activities, such as industrial therapy; occupational therapy; group leader program; parties and entertainment; and, in the negative counterpart, items suggesting improvement, or the need to provide activities of this type.

The third category—on the physical surroundings—includes praising or criticizing the physical facilities of the ward and of the hospital, such items as liking the open door, "made a better place to live," or objecting to smoking in the TV room.

The fourth category, the program and its administration, refers to administration in a very broad sense and is the most varied of the categories from question to question. It includes the matter of the efficiency of running the ward, the liking or disliking

of aspects of the ward program, comments on the general organization and operation of the hospital, references to the ward meetings, the favoring or criticizing of somatic therapies, or the expressing of the need for more individual help. In the questions about patient government and community meetings, it includes praise and criticism of the manner in which the meetings are conducted, of the therapeutic techniques, and of the therapist, and also includes statements like "gives patients a voice in hospital policies."

The last category deals with the personal gains or losses which the individual feels he has experienced. Thus, it pertains to such items as "increased self-confidence," "increase of self-understanding and responsibility," and "bored by the meetings."

In summary, the responses contained in the answers were scored as items which were grouped into five categories. Separate tabulations were made for positive and negative items, on the basis of the positive or negative characteristics of the responses, regardless of whether they were expressed in the positive or negative question. Replies merely indicating the respondent's positive or negative attitudes about a subject were not included in the item analysis.

Upon analyzing the content of the answers, it became apparent that the positive replies generally were more fully elaborated than the negative ones. To investigate this further, three indicators of the degree of agreement—the ratio of the number of responses per person, the ratio of the number of responses per item, and the percentage of items with three or more responses—were developed, utilizing the positive and negative responses separately from each area. While these results, given in Table 2, indicate that the degree of agreement is generally greater for the positive responses than for the negative, they also reveal considerable variation between the various indicators and between the areas.

The positive responses to the ward come the nearest to unanimity on all three of these measures, while the furthest from unanimity generally concerned the benefits of hospitalization. This lack of unanimity may be the result of the large number of non-descript answers, such as "It has been beneficial," which were given for the last question, and which were not scored as responses in this analysis.

Table 2. Indicators of the Possible Existence of Group Norms.
Measurements of the degree of agreement

Area		Number of Responses	Ratio I* No. of Responses Per Person	Ratio II** No. of Responses Per Item	Percentage of Items With 3 or More Responses
I. Ward	pos.	133	3.0	4.2	62
	neg.	47	1.6	1.5	13
II. Patient government	pos.	73	2.0	2.4	40
	neg.	36	1.6	1.8	25
III. Tuesday meeting	pos.	64	1.8	3.2	50
	neg.	13	1.3	1.6	25
IV. Thursday meeting	pos.	36	1.2	1.8	30
	neg.	17	1.0	2.1	25
V. Hospital program	pos.	68	2.2	2.2	26
	neg.	39	1.9	1.3	13
VI. Benefits of hospitalization	pos.	43	1.1	1.5	7
	neg.	22	1.0	1.5	7

*This ratio was calculated by dividing the number of responses by the number of persons who gave such a response. For example, the number of persons who gave a positive response was obtained by adding together all those who had responded positively to the area, plus those who had a neutral response, plus those who were negative but had given some positive items. A similar calculation was made using the appropriate responses for the negative responses.

**This ratio was obtained by dividing the number of responses by the respective number of positive or negative items.

When considered individually, each of these ratios measures different aspects of the degree of agreement. The first ratio measures the average number of responses made by each individual who indicated any positive or negative attitudes about a given area. This ratio was higher for the areas in which two questions were asked. Thus, it would appear that while the number of questions asked in an area does not influence the degree of positiveness shown for that area, it does affect the number of responses given. When only the ratios for the negative items are considered, the highest ratio of responses per person is in the area of the hospital program, indicating that each of those who responded to this part of the questionnaire had more negative things to report than for any other area. This figure is even more striking when it is compared with the corresponding meas-

ures of the number of responses per item and the percentage of items with three or more responses, both of which were very low. Thus, it was inferred that, while each person had many negative things to say about the hospital program, there was little agreement within the group regarding their criticisms.

As just indicated, the second ratio, number of responses per item, directly measures the degree of agreement between the group members and, of the three measures, is the best indicator of consensus. This ratio shows that the greatest agreement was expressed in the positive evaluation of the ward and of the Tuesday meetings. The least was shown in the unfavorable responses to the hospital program. The greatest agreement among negative responses concerned the Thursday meetings. Only in this case was any indicator greater for the negative than for the positive responses. This indicates that there was a large amount of shared criticism about these meetings.

Since the number of responses per person is generally similar to the number of responses per item, it would appear that the readiness to respond to the questions may be influenced by the group norms which have been developed. If this is the case, it would help to explain the greater number of unanswered negative questions.

The total number of responses divided into five categories for each question is given in Table 3. The greatest number of itemizable responses, 133, was received on the positive aspects of the ward and the fewest, 13, about the negative aspects of the Wilmer meeting.

By far the largest number of responses for a single item was given for questions 1 and 2; 19 respondents "liked having open doors." This prominence is certainly associated with the fact that the ward had just been opened a few weeks prior to administering the questionnaire. In this regard, it should be noted that little mention of the open doors was made in the community meetings immediately after this change was made, and this led some staff members to conclude that the patients were not especially concerned about the development. The results of this questionnaire effectively disprove this assumption and allow one to ascertain the view of the patients more accurately.

In comparing the responses toward the ward with those toward the hospital, it was found that while the positive responses toward

Table 3. Distribution of Responses by Category for Each Area. Tabulated by the number of responses and by percentages of positive or negative responses for each area

Categories of responses	Area I The Ward				Area II Patient Government				Area III Tuesday Meeting			
	Pos.		Neg.		Pos.		Neg.		Pos.		Neg.	
	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.
I. Group attitudes—atmosphere ..	31	41	30	14	21	15	22	8	6	4	0	0
II. Activities	11	15	6	3	5	4	0	0	0	0	0	0
III. Physical surroundings	24	32	32	15	8	6	0	0	0	0	0	0
IV. Specific program— administration thereof	16	21	26	12	14	10	53	19	31	20	23	3
V. Individual gains or losses ...	18	24	6	3	52	38	25	9	63	40	77	10
Total responses	100	133	100	47	100	73	100	36	100	64	100	13

Table 3. Distribution of Responses by Category for Each Area. Tabulated by the number of responses and by percentages of positive or negative responses for each area (concluded)

Categories of responses	Area IV Thursday Meeting				Area V Hospital Program				Area VI Benefits of Hospitalization				Total Questionnaire			
	Pos.	Per cent	No.	Neg.	Pos.	Per cent	No.	Neg.	Pos.	Per cent	No.	Neg.	Pos.	Per cent	No.	Neg.
I. Group attitudes— atmosphere	33	12	0	0	7	5	26	10	7	3	9	2	19	80	20	34
II. Activities	3	1	0	0	41	28	18	7	2	1	5	1	12	49	6	11
III. Physical surroundings	3	1	0	0	4	3	15	6	2	1	0	0	10	43	12	21
IV. Specific program— administration thereof	14	5	59	10	30	20	36	14	5	2	41	9	19	78	38	67
V. Individual gains or losses	47	17	41	7	18	12	5	2	84	36	45	10	40	167	24	41
Total responses	100	36	100	17	100	68	100	39	100	43	100	22	100	417	100	174

the ward emphasized the ward atmosphere and attitudes (31 per cent) and the liking for the physical conditions of the ward, including the open doors (24 per cent), those toward the hospital emphasized the activities, especially industrial therapy (41 per cent) and the general treatment program of the hospital (30 per cent), replies which will later be analyzed in detail. The criticism of the ward also emphasized physical surroundings and ward atmosphere, but in no case was the number of negative responses in a given category as large as the number of positive responses. On the other hand, in the case of the hospital program, criticisms of hospital policies and of the hospital atmosphere tended to predominate (36 per cent and 26 per cent respectively). Primarily, the restrictions on "fraternization" and the lack of canteen facilities were what the patients opposed, and the need for more individual help was expressed on both ward and hospital level.

While the Thursday community meeting and patient government were largely considered to be responsible for improving the ward atmosphere and attitudes, the Tuesday meeting was described predominantly as providing personal benefits. But it should also be noted that there was marked similarity between the patients' perspectives of these community meetings and of patient government. Even in the question regarding patient government, of which the expressed major purpose was the improvement of the ward and the ward conditions, only 45 per cent of the positive responses deal with general ward affairs. When the responses to these three areas—patient government and the two social-therapy meetings—are considered jointly, it is found that 55 per cent of the positive responses deal with individual emotional gains, while 49 per cent of the negative responses are critical of the way the meetings are conducted. When the positive and negative responses for each category are totaled for the entire questionnaire, individual gains by far outrank any other category, constituting 40 per cent of all positive responses, and ranking second among the negative responses.

To interpret further the replies to the questions on hospital program and the benefits of hospitalization, it was found convenient to establish categories different from those already described. These subcategories were used to study: (1) types of treatment, (2) comparison of attitudes toward ward and hospital,

and (3) relationship between the hospital and the external community.

Many of the items in answer to the questions about the hospital program dealt with various aspects of what has traditionally been considered treatment in the mental hospital setting. In this analysis, three types of treatment have been distinguished: (1) somatic treatments, which include medications, electric shock treatment, and hydrotherapy; (2) verbal therapies, which include individual psychotherapy and counseling, group therapy and community meetings; and (3) rehabilitation therapies, such as industrial therapy (IT), occupational therapy (OT) and the group leader program.

Of the positive responses toward the hospital program, 46 per cent mentioned one of these treatment programs as helpful. These were distributed as follows:

Somatic therapies:	5
Verbal therapies:	9
Rehabilitation therapies:	17
Total	31
Nontreatment responses:	37

Thus, 25 per cent of the total responses dealt with some form of rehabilitation therapy, and 11 out of these 17 positive responses specifically named IT. On the other hand, only 23 per cent of the negative responses to the question regarding the hospital were concerned with treatment programs:

Somatic therapies:	2
Verbal therapies:	6
Rehabilitation therapies:	1
Total	9
Nontreatment responses:	30

A comparison of these two distributions shows that the rehabilitation therapies are best accepted by the patients, while the verbal therapies receive the greatest criticism. Apparently, more patients have difficulty in accepting the verbal therapy program as treatment; but, when asked about the meeting specifically, they described them, predominantly, as providing individual gains.

The items in the three categories of attitudes and atmosphere, physical surroundings, and program and administration could be

divided into those that referred to the ward and its immediate program and those that referred to the general hospital policies and attitudes outside of the ward program. Of the 23 positive responses to the hospital program in these three categories which could readily be identified as referring either to ward or the hospital, 18 dealt with the immediate ward setting, and only five dealt with the more general hospital setting. On the other hand, of the 28 negative responses, only nine dealt with the immediate ward setting, while 19 dealt with the hospital in general. This difference is significant at .01 level. Thus it seems reasonable to conclude that the attitudes of the patients toward the hospital were much more negative than toward the ward, even though this negativism was not directly expressed.

The answers to the last question regarding the benefits of hospitalization indicated a dimension which had not previously been touched. A number of the items referred to the relations between the patients and the external community to which they hoped to return. Of the positive responses only two referred to the relationship of the individual to the outside, and both of these pertained to their families. In contrast to this, 10 of a total of 22 negative responses were concerned with the effects of hospitalization on the post-hospital life of the individual. Five responses dealt with the effects of continued or prolonged hospitalization; and two responses expressed concern over the fear that the gap between the attitudes and conditions within the hospital and those of the outside community would make readjustment difficult. Thus, it would appear that the patients were worried about the separation between the hospital community and the rest of society and felt this as a threat to their future adjustment.

Positive responses in the individual gains category to the question on hospital benefits were broken down into subcategories, to obtain greater insight into the perception of these gains:

Improved physical health:	9
Learned to socialize better:	3
Better able to handle and understand one's own problems:..	9
General emotional and psychological improvement:	9
Greater self-understanding and learning about self:	6
Total	36

Finally, the total responses to the individual gains category from all questions were analyzed to determine the amount of

introspection shown by the patients in assessing their individual gains. The subcategories display the tabulated distribution of responses:

	Pos.	Neg.
Freedom of self-expression	17	1
Staff-patient relations	10	1
Increased self-confidence and responsibility	18	1
Dignity and self-respect	6	0
Self-understanding	31	15
Understanding of others	7	3
Feeling of belonging	7	0
Freedom	12	4
Other gains	59	16
Totals	167	41

The subcategory "other gains" included: improved physical health; gaining of knowledge and information; statements oriented toward repressive elements, as being kept busy; learning to socialize; and nonspecific indications as to personal benefit.

This last tabulation reveals that most of the responses pertaining to individual gains during hospitalization are in agreement with the goals of the therapeutic community, which stresses improvement in interpersonal relationships and self-understanding, and encourages self-expression. Its limitations are recognized, however, as evidenced by the high proportion of responses indicating failure to gain self-understanding.

SUMMARY AND CONCLUSION

In this analysis of a questionnaire given to 56 women patients on an acute treatment ward, the attempt has been made to show some of the benefits which can be gained through the use of a questionnaire in determining patients' attitudes toward the ward program, which in this particular case was modeled after therapeutic community concepts. By its use, one could more clearly determine which aspects of the program the patients accepted or disliked, and it was also possible to understand better some of the dynamics of the patients' adjustment to the program.

A marked difference between the patients' attitudes toward the ward and the hospital was found, the ward atmosphere and administration being much more favorably viewed than those of the hospital. Second, it was found that a certain period of time was necessary for integration into the ward. While this in itself was

not a surprising discovery, the writers had been unaware of the differential in integration time for the various aspects of the program. With the goal of shortening hospitalization, efforts should be directed toward decreasing this period, especially in regard to verbal therapies.

There was generally a greater consensus of the group on the positive items than on the negative ones, which may indicate greater development of favorable group norms toward the program. Certain discrepancies were apparent in the evaluation of the hospital treatment. The patients first stressed the rehabilitation therapies and, second, the somatic therapies as being helpful, and were generally ambivalent about verbal therapies. Yet, when describing the benefits from hospitalization, they emphasized the personal gains which they associated with the therapeutic community and with patient government meetings.

The patients saw hospitalization as generally helpful to themselves, but considerable anxiety was expressed concerning their separations from the community and their families. It was felt that a bridge between hospital and community was needed to make readjustment easier. The establishing of day and night hospitals might help alleviate this separation.

A unique feature of the program was provided by Dr. Wilmer's therapeutic community demonstration, which the patients viewed in a very favorable light. Although negative feelings were generally expressed more sparingly than positive ones, the patients felt free enough to criticize the ward doctor's community meeting more than any other area, but they were able to distinguish between their liking for the ward doctor and the efficacy of her meetings.

Most prominent among the patients' responses, were those related to individual gains obtained through hospitalization. A large number of these dealt with increased self-understanding and self-expression and improved interpersonal relationships.

While no claim is made that the positive results obtained by the questionnaire prove the therapeutic effectiveness of the program, progress was not halted during this period. The average stay in the hospital decreased 32 days; transfers to other wards were reduced by 10.6 per cent; and the discharge rate increased 23.4 per cent as compared with data available for two years preceding this program. Traditionally, treatment programs and hos-

pital policies have been developed by administrative decisions, giving little consideration to the patients' reactions or to their proposals for improvement. However, since the goals of social therapies include the patients as therapeutic agents, the authors believe that an evaluation of their attitudes assists in implementing a therapeutic program that is better tailored to the patients' needs.

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INTERNAL MIGRATION AND MENTAL DISEASE IN NORWAY*

BY CHR. ASTRUP, M.D., AND ØRNULV ØDEGAED, M.D.

In a previous publication, Ødegård showed that the incidence of mental disorder (as measured by first admissions to mental hospitals) is higher among the Norwegian-born of Minnesota than among the native-born of this state or among Norwegians at home. On the other hand, an investigation of migration within Norway showed *lower* admission rates among the migrants than among those who were still residing in their community of birth. This contradiction made further investigation desirable, but unfortunately the statistical data are unsatisfactory.

For the hospital material, complete data are available as to community of birth and community of residence on admission, but nothing is known as to where the patient may have lived in the intervening years. The census data on the general population are even less complete. In 1920 and 1930, the distribution by place of birth, place of residence and sex is given for all ages above 15, but not separately for age groups. The census of 1946 does not even distinguish between the sexes; and in 1950 the registration of birth-place was left out altogether.

For two 15-year periods 1916-30 and 1931-45 it has, nevertheless been possible to compute relative admission rates separately for those still living in their communities of birth and the remaining or "migrant" part of the population. To a limited extent, it has also been possible to study the different routes of migration.

A survey of the demographic pattern of the population of Norway with regard to internal migration is given in Table 1. Half of the population live in rural districts proper, with communities where more than half of the population reside in densely-populated districts excluded. Of this rural population, 70 per cent live in their communities of birth; 17 per cent were born in rural communities in the same counties where they now live; 8 per cent were born in other rural communities; and only 5 per cent in cities.

Two groups of communities, which are administratively classified as rural, are singled out for special investigation in this paper, because more than half of their population lives in densely popu-

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Table 1. Percentage Distribution of Adult Population of Norway by Community of Birth and Community of Present Residence. Mean of Census Data 1930 and 1946

	Per cent
Resident in Rural Districts Proper:	
Born in Same Community	70
Born in Rural Communities in Same County	17
Born in Rural Communities in Other Counties	8
Born in Cities	5
Resident in Semi-Urban Districts:	
Born in Same Community	53
Born in Rural Communities in Same County	23
Born in Rural Communities in Other Counties	10
Born in Cities	14
Resident in Suburban Districts:	
Born in Same Community	30
Born in Rural Communities in Same County	15
Born in Rural Communities in Other Counties	21
Born in Adjoining City	23
Born in Other Cities	11
Resident in Cities Other Than Oslo and Bergen:	
Born in Same City	46
Born in Rural Districts in Same County	28
Born in Rural Districts in Other Counties	14
Born in Other Cities	12
Resident in Oslo:	
Born in Oslo	45
Born in Rural Districts	38
Born in Other Cities	17

lated sections which are more urban than rural in character. These are:

1. *Semi-Urban Communities*, in which the densely populated sections have grown up independently of any city, as local centers of trade and industry. In this group the migration pattern is nearly the same as in cities.

2. *Suburban Communities*, in which the densely populated sections have developed outside the administrative borders of cities. These communities present a pattern which is relatively unstable, with only 30 per cent of the residents born within the community, while 36 per cent are migrants from rural districts and 34 per cent from cities; 23 per cent were born in the city adjoining the suburb, but the actual migration from city to suburbs is considerably greater than is indicated by this percentage, as a number of migrants to the city move further on again to the suburbs.

In cities other than Oslo and Bergen (none of them having more than 60,000 inhabitants) 46 per cent are born in the city, while 42 per cent have immigrated from rural communities, mostly in the same county, and 12 per cent have come from other cities. In Oslo the pattern is closely similar to this, while in Bergen the percentage of non-migrants is somewhat higher.

The percentage of migrants is somewhat higher in women than in men, particularly in Oslo and Bergen. Within the period of investigation, there is no time-trend of any importance, although the percentage of migrants has increased slightly in the rural districts, while it has decreased in cities and semi-urban districts.

On the whole, the population of Norway may be described as relatively stable. Migration takes place on a moderate scale, and much of it is merely within the same county. (In this connection it should be noted that Norway, with a population of 3,200,000 in 1946, is divided into 20 counties. The rural districts comprise 680 local communities. This means that the administrative units are small in comparison with most other countries.) There is the usual migration toward cities and semi-urban districts, but the process of industrialization and urbanization has been slow and on a moderate scale. The suburbs are the most unstable because migration from the adjoining cities is added to the usual rural-urban migration.

It might be added that only 2 per cent of the adult population are foreign-born, and most of these have immigrated from neighboring Sweden or Denmark.

Tables 2 to 4 give relative rates of mental hospital first admissions, based upon the method of calculated numbers. For each population group to be examined, the number of first admissions is determined by age groups of 10 years, the statistical material being available in the form of a national register of all hospital admissions. From the number of patients the corresponding population is calculated, under the assumption that the admission rate in each age group is equal to the mean rate for Norway 1926-35. The resulting calculated-population is compared with the population actually observed in the census, and relative admission rates can be computed. A relative admission rate of 120 means that, in its particular population group, the number of first admissions corresponds to a morbidity of 120 per cent of the average for Norway.

Table 2. Relative Rates of First Admission (Rate for Norway 1926-35=100) for Nonmigrants and for Various Types of Migrants

Districts and Areas of Origin of Migrants	1916-30				1931-45	
	Men		Women		Both Sexes	
	Nonmig.	Mig.	Nonmig.	Mig.	Nonmig.	Mig.
<i>Rural Districts in Oslo Area</i>						
Rural comm., same area	89	78—	98	74—	120	93**
Other rural communities		74—		90—		98**
City of Oslo		85—		68**		102*
All other cities		91—		84—		118—
<i>All Other Rural Districts</i>						
Rural comm., same county	96	59***	87	51***	108	66***
Rural comm., other counties		66***		65***		87***
Cities, same counties		70***		74—		92***
Cities, other counties		60***		59***		100
<i>City of Oslo</i>						
Rural districts (anywhere)	162	122***	129	148*	171	208***
Cities (anywhere)		153—		171***		263***
<i>City of Bergen</i>						
Rural districts (anywhere)	165	60***	178	122***	134	127—
Cities (anywhere)		108***		113***		127—
<i>All Other Cities</i>						
Rural comm., same county	137	74***	114	69***	137	85***
Rural comm., other counties		90***		81***		89***
Cities, same county		64***		59***		96***
Cities, other counties		72***		81***		107***

*** $P \leq .001$, ** $P \leq .01$, * $P \leq .05$

The asterisks indicate the statistical significance of the difference between nonmigrant and migrant group, according to the conventional levels.

The tables show that nearly everywhere the rates of admission to psychiatric hospitals are much higher in the nonmigrant part of the population. There seems to be a tendency for the short-distance migrants to have particularly low admission rates. People who have moved from one community to another within the same county, have somewhat lower rates than migrants who have moved to other counties. The differences are not always statistically significant, but the trend is fairly consistent. The explanation may be that short-distance migrants find it particularly easy to return to their homes in cases of beginning mental illness, particularly as many of them are likely to be seasonal migrants in farm labor, forestry or fishing.

There is a tendency for migrants from cities to have higher admission rates than migrants from rural districts, regardless of the destination of their migration. This trend is most marked in the last 15-year period, while in 1916-30, it is found only for Oslo, and, as far as the male migrants go, for Bergen. Selective migration is the most likely explanation: Migration from rural districts is for several reasons typical of our culture and our times. Migration from cities, be it to other cities or to rural districts, is, somehow, contrary to this typical trend, and may therefore more often be connected with personal problems of social adjustment, or with initial psychotic symptoms.

It has been shown in a previous paper by one of the writers that the populations of suburbs have much lower admission rates than the corresponding cities. Table 3 shows that in suburbs the admission rates are generally lower for migrants than for non-migrants, but Oslo is a notable exception. The capital has a much higher admission rate to psychiatric hospitals than any other part of Norway, and this trend will evidently, to some extent, follow the migrants from the city to its suburbs.

The semi-urban communities differ from the strictly rural districts, and also from the cities, in that immigration to them has taken part on a larger scale, and, above all, more recently. In spite of these differences, these districts show practically the same difference between migrants and nonmigrants as the truly rural districts.

When different parts of the country are compared, one finds the migrant-nonmigrant differential to be most marked in south-western Norway, while in the northern counties it is not even

Table 3. Relative Rates of First Admission for Migrants and Nonmigrants in Various Parts of Norway (Rate for Norway 1926-35=100.)

	1916-30, Men Only		1931-45, Men and Women	
	Nonmigrant	Migrant	Nonmigrant	Migrant
<i>Rural Districts Proper</i>				
Southeastern	102	75**	118	86***
Eastern	93	62***	112	77***
Southern and western	112	55***	120	74***
Northern	76	69—	89	55***
Total	95	64***	108	72***
<i>Semi-Urban Districts</i>				
Southeastern and eastern ..	115	69***	121	104*
Southern and western	122	80**	105	77**
Northern	89	83—	94	79—
Total	111	75***	115	99**
<i>Suburban Districts</i>				
Southeastern and eastern ...	95	65**	112	94*
Southern and western	85	50*	114	90*
Northern	110	106—	94	79—
Total (exclusive of Oslo)	93	66***	111	90***
<i>Cities</i>				
Southeastern and eastern ..	105	70***	147	101***
Southern and western	158	85***	131	90***
Northern	162	69***	133	71***
Bergen	165	67***	134	127—
Total (exclusive of Oslo)	144	76***	138	95***
City of Oslo	162	128***	171	225***
Suburbs of Oslo	69	85—	119	106—

*** $P \leq .001$, ** $P \leq .01$, * $P \leq .05$

always significant. It is suggestive that the *general admission rates* are highest in the southwest and lowest in the north, but why this should influence the migration pattern is not clear. Northern Norway is seen to come much closer to the usual pattern in the last of the two 15-year periods, which suggests some connection with a low rate of hospitalization caused by inadequate hospital facilities and problems of transportation. Apparently the migration pattern does not emerge unless the psychiatric hospital system has attained a certain level of efficiency. This would agree with the observation that in the *cities* of northern Norway the difference between migrants and nonmigrants is very marked indeed.

Generally the trends are the same in both 15-year periods. The most interesting exception is that of Oslo. In 1916-30 the admission rate is found to be lower in migrants than in nonmigrants

while in 1931-45 the migrants have a significantly higher rate. A similar development is seen in Bergen: The migrants have a much lower admission rate during the first period, while in the second period this difference has nearly disappeared. One might conclude that the immigration to the larger cities has changed in character, but there is nothing to lend positive support to this theory. Most likely the explanation is that since 1930 the hospitalization of senile psychoses has increased rapidly in Oslo, and to some extent in Bergen, while in the remainder of the country this increase has been much less marked. Now the age distribution of the migrant population is not known, but it is bound to be higher than that of the city-born. Consequently the increasing number of older patients will raise the admission rate more for the migrants than for the nonmigrants. As age-specific rates cannot be calculated, it is impossible to show this conclusively. The age distribution of the first admissions has changed radically, however: In 1916-30 only 9 per cent of the migrant admissions were above 70 years of age, as against 20 per cent in 1931-45.

A comparison of the sexes can be made for the first 15-year period only. Table 2 shows that the difference between migrant and nonmigrant admission rates tends to be the same in men as in women. The only exception is Oslo. Here, the male migrants have the usual lower admission rates, the difference being significant for the migrants from rural districts, while for migrants from other cities, it is small and insignificant. The female migrants, on the other hand, have *higher admission rates* than the city-born women. Now there is a clear difference between male and female immigrants to Oslo with regard to socio-economic level. Among the men a much larger proportion takes up skilled labor of some kind, while a majority of the women (at least up to 1940) went into domestic service and so on. As has been shown by Ødegård, the admission rate for domestic servants is much higher than for any other occupational group. In the male sex the only comparable groups are farm laborers and seamen who play a minor part in the population of Oslo.

Table 4 shows that in Oslo, as well as in the rest of the country, the immigrants from Sweden and Denmark have admission rates of the same order as corresponding groups of national migrants. During the second 15-year period, they tend to be somewhat higher than in the first. The majority of these immigrants are Swedish,

and this immigration had its maximum in the years previous to 1905. Consequently the Swedish-born population in Norway has decreased slowly in numbers, while it has increased in mean age. As has been mentioned, age-specific admission rates cannot be calculated, but the data indicate that older patients constitute a large proportion of this immigrant group. This was found to be the case for the Norwegian-born of Minnesota as well, and may be due to social factors influencing the hospitalization of the mentally ill: Elderly immigrants are less likely than natives to live in a stable family setting, with relatives who are able and willing to care for them in case of mental disorder.

Previously published data for 1926-35 indicated a somewhat increased morbidity among the immigrants from Sweden and Denmark. The writers did not then take into consideration that relatively many of them were resident in Oslo, with its high general admission rate. When Oslo and the remainder of the country are considered separately, the difference disappears, which indicates that it was a statistical artifact.

Immigrants from countries other than Sweden and Denmark are few, and the corresponding admission rates are, therefore, based upon small numbers of cases. During the first 15-year period, they seem to have had admission rates similar to those of the Scandinavian immigrants. In the period of 1931-45, on the other hand, the rates are considerably raised, possibly because of the influx of displaced persons during the years pre-

Table 4. Relative Rates of First Admission for Foreign-born, as Compared with Rates in Comparable Groups of Internal Migrants

	1916-30		1931-45	
	Men	Women	Total	Both Sexes
<i>Resident in Oslo:</i>				
Born in Denmark and Sweden	133	155	144	277
Born in other foreign countries	126	123	125	339
Born in Norway outside of Oslo ..	129	155	145	225
<i>Resident in Norway outside of Oslo:</i>				
Born in Denmark and Sweden	67	57	62	98
Born in other foreign countries....	66	93	80	123
Long-distance migrants within Norway	71	77	74	97
<i>Total, resident in Norway:</i>				
Born in Denmark and Sweden	80	80	80	143
Born in other foreign countries ..	82	100	91	163
Internal migrants	88	101	95	131

vicious to and immediately after 1939. Eitinger has shown, with somewhat later material, that the mental morbidity is very high in this group.

The present findings seem to indicate that migrants have lower admission rates than nonmigrants, regardless of the type and the direction of the migration. Among the possible explanations, systematic errors of registration have to be considered. The community of birth is given as unknown in 1.1 per cent of the hospital material and in less than 1 per cent of the census data, a difference which is clearly without any significance. There remains the possibility that the erroneous recording of the community of birth as *being the same* as the community of residence is rather more likely to happen than the opposite error. This would, indeed, be a likely consequence of human inertia, but there is no particular reason to believe that this happens more frequently in hospital statistics than in the census returns, or vice versa.

A difference in the tendency to have the mentally ill hospitalized is not likely to play any role in the present problem. It is not easy to see why patients who remain in their community of birth should be more likely to be admitted than those who have moved, and who have in most cases lost, rather than gained, in the way of social and family connections. It has been shown in a previous publication by Ødegård that the admission rate is comparatively low in young men and women not gainfully employed, most of whom are resident with their parents as typical "nonmigrants." The discharge-pattern points in the same direction: There is no tendency for persons not gainfully employed to be discharged particularly late (or for that matter particularly early). They seem to be received by their relatives in the same way as other groups of patients.

It has already been mentioned that the census data on internal migration are too incomplete to allow a very detailed statistical analysis of the hospital material, for instance with regard to such important variables as age, marital status and occupation. This makes it easy to overlook statistical artifacts. It is possible, for instance, that the nonmigrants belong to socio-economic groups with high rates of admission to psychiatric hospitals. From what is known about the admission rates in various occupational groups, this is not likely, however. The rates are particularly high in such groups as domestic servants and seamen, who are certainly

migrant rather than the opposite. Farm laborers are likely to be short-distance migrants, and their high admission rate is certainly not consistent with the low rates in the short-distance migrant group.

Admission rates are much higher among single persons than for the married, and a moderate over-representation of single persons in the nonmigrant group would explain this group's raised admission rate. It is possible to carry out the statistical calculations so as to adjust somehow, even for this factor, and in a previous publication by Ødegård this was actually done. A comparison with the present data seems to show that the difference between migrants and nonmigrants was actually brought down by this adjustment for marital condition, but it was in no way eliminated. It is doubtful, however, if this adjustment is statistically sound. Marital status is likely to influence mental morbidity, be it by selective mating, or by some sort of social and personal protection. In any case it is hardly a factor which should be *eliminated*. It should be *controlled* by calculation of specific admission rates for the single and the married, but unfortunately the necessary census data are lacking.

An over-all evaluation of the possible sources of error seems to justify the assumption that the lowered admission rates in migrants correspond to a lower mental morbidity, and the hypothesis of a selective migration suggests itself as a likely explanation. Such a migration, in connection with initial psychotic symptoms or with pre-psychotic personality traits, would be rather irrelevant from a psychopathological point of view, however, if it were a mere passive incident, that is, if a patient were sent home by his employer or by the authorities, or fetched home by his relatives, during the initial stages of his mental illness and previous to hospitalization. In order to throw some light upon this problem, the writers have studied a representative sample of material: 756 case histories of patients suffering from schizophrenia or other functional psychoses, with particular regard to the details of internal migration.

In this group of mental hospital patients, internal migration was found to have taken place around the time of onset of the psychosis in 56 cases or 7.4 per cent; 29 of these 56 patients moved back to their home communities, while 27 moved away from them. A causal connection between the migration and the

psychotic onset was in all these cases possible, because of the coincidence in time. It was also more or less probable in view of the clinical histories, but it was in no way certain. The figure of 7.4 per cent of migrants, therefore, represents a definite maximum. Most of the migrants were young, single persons, with schizophrenic or paranoid conditions.

The 27 who left home were motivated by general restlessness and maladaptation or by more specific conflicts with their environment. Sometimes definite psychotic symptoms were responsible; but more frequently pre-psychotic traits of fairly long-standing, "constitutional" character. Only two of the 27 were short-distance migrants. Among the remaining 25, who moved to other counties, 15 went to Oslo.

Among the 29 who went back home, six were short-distance migrants. Twenty-three moved from one county back to another, and 11 of these patients came from Oslo. Generally these patients returned to parents or other relatives in the country because they had failed in their work in some city.

Only two of the 56 migrants were Oslo natives. One left his home in the city, and one returned to it. This may seem to be an under-representation; but actually internal migration is comparatively rare in people who have their homes in the capital. Overseas migration in possible connection with onset was found in 29 cases or 3.8 per cent of the 756, but such cases are probably over-represented in Gaustad Hospital, from which the cases are taken (because of its location in Oslo). All of them returned to Norway or were deported (mostly from the United States) because of mental illness, but 12 were probably already psychotic at the time of their emigration.

A special group of 207 single women patients who had been employed in domestic work was selected as being particularly mobile with regard to residence and employment. Sixty-four or 31 per cent were found to have migrated around the time of onset of illness; 28 moved back home, mostly from Oslo; while another 28 left their home communities for Oslo or some other city, and eight were overseas migrants. Only five of these domestic workers were short-distance migrants. Even in this exceptionally unstable group, mental disorder evidently is relatively seldom related to this type of migration.

This clinical study shows that statistics based upon place of residence at the time of admission and place of birth fail to give a complete picture of the extent and nature of internal migration. Some 3.8 per cent of the writers' sample returned to their homes after the outbreak of illness and previous to hospital admission. These cases should preferably have been registered according to their residences before they started upon their home journeys. A correction of this error would decrease admission rates very slightly for nonmigrants, particularly in the rural districts, and raise them somewhat more for migrants, particularly for long-distance migrants from rural to urban areas.

Now, one might object that, in the writers' sample, a corresponding number of patients leave their homes and *become migrants* around the time of onset of illness, and they should offset those who *become nonmigrants* at the time of onset. The two groups do not, however, represent entirely opposite types of migration, in that the patients who leave their homes do so on their own initiatives (even though the motives may be pathological), while those who move back home are frequently passive victims of the arrangements of others. The best correction, therefore, would be to transfer such "passive home-comers" from the nonmigrant to the migrant group. The problem is that their share of the 3.8 per cent who return home is uncertain, as these patients represent all degrees of passivity. It is the writers' impression that they would be rather less than 50 per cent, which would mean that this group is too small to represent a serious statistical error, and that it cannot possibly be responsible for the migrant-non-migrant differential.

In the Gaustad hospital sample 7.4 per cent of the patients were involved in some internal migration in possible connection with psychotic symptoms. In relation to the present problem, this represents a selective migration based upon psychotic symptoms. The material shows that such a selection exists, but that it cannot explain the lower admission rates in migrants, because it leads to re-immigration as often as to emigration. If selective migration is a decisive factor, one is, therefore, led to assume that it mainly takes place in the pre-psychotic period, and upon the basis of personality traits or social characteristics existing previous to the onset of mental disorder.

It has been shown by Malzberg, Ødegård and others that overseas emigration is connected with increased admission rates to psychiatric hospitals. If selective migration is to be held responsible for these differentials, then one has to make the assumption that selection differs according to type of migration, which is in fact most likely. Internal migration is less final and irrevocable than emigration, and more likely to be meant as an experiment of limited scope and duration. Often it is even a natural and well-prepared step in the progress of a young person who has acquired some special training. Clearly, the difference in mental attitude and social setting might easily lead to opposite types of selection. But even the environmental stress of migration weighs much more heavily upon the overseas emigrant, who has to adjust to a radically different social situation, who generally has to break his contacts with family and friends, and who is generally unable to make elaborate preparations. The difference between overseas and internal migrants with regard to mental health may, therefore, be taken as a point in favor of the environmental hypothesis.

Malzberg and Lee found the same raised admission rates in migrants to New York State from other parts of the country as in overseas immigrants. This agrees with the writers' findings for the migration to Oslo, which is the only type of migration within Norway comparable to the migration to New York. Recent data from Sweden and Denmark show a relatively low prevalence and incidence of mental disorder in typical immigration districts, which seems to confirm that morbidity is high in the part of the population which is "left behind."

In conclusion, it seems justified to state that the findings presented here suggest the existence of selective migration, without giving any definite proof. Even less do they disprove the existence of some specific environmental stress which weighs more heavily upon nonmigrants and contributes to their high admission rates. More adequate census data (such as are available in the United States and Sweden) would make a further approach to the solution of the Norwegian problem possible.

While the statistical approach has its obvious shortcomings, even an intensive clinical study of individual cases is hardly more efficient in untangling the complex network of causes and effects. In the writers' own clinical material, one finds, for instance, the

common example of the young and gifted country boy who goes to town to make use of his exceptional abilities. This appears to be a pure case of "positive" social selection; but when he breaks down five years later in a psychosis, the problem of causation seems far from clear. Did a predisposition toward mental disorder already exist at the time of migration, and if so, was it one of the factors behind migration? Or is he a victim of social stress in unfamiliar surroundings? The same applies to the shy and somewhat handicapped country girl who decides to stay home, and who develops a psychosis. Would she have fared better in another environment? It is the writers' impression that social and personal stress does not tend to be specific for migrant or nonmigrant situations, but is more likely to be related to life experience, which is a specific problem for *particular persons*. It depends upon the individual nature-nurture situation of each human being whether he is vulnerable or resistant toward migrant or nonmigrant stress, or to neither of them, or possibly to both. In this state of flux, statistical studies can, under favorable circumstances, contribute by exploring and mapping out the currents along which the individuals are most likely to navigate or drift.

SUMMARY

The relations of mental disease to internal migration have been studied in a material of first admissions to Norwegian psychiatric hospitals. The population of Norway is comparatively stable with regard to change of residence. Also, migration within the country does not lead to dramatic environmental changes. Nevertheless, the rates of first admission are significantly lower for migrants than for nonmigrants (the latter being defined as persons resident in their communities of birth at the time of the census, respectively the time of first admission). Particularly low rates were connected with short-distance migration (within the same county) as well as with migration from rural districts to cities. Migrants from cities tend to have higher rates, probably because this type of migration is more atypical of the population. The city of Oslo forms an exception, in that migrants to the city have higher rates than the city-born, particularly for women. This "big-city trend" seems to be on the increase in Norway, and corresponds to the findings in New York State of higher admission rates in interstate migrants. The authors regard selective migration as the

most likely explanation for their findings, and discuss why such selection should lead to an increase in morbidity in overseas migrants, as against a decrease in migrants within the country.

Gaustad Psychiatric Hospital
Oslo, Norway

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REVIEW OF MENTAL HYGIENE AND RELATED LEGISLATION FOR THE YEAR 1960

BY E. DAVID WILEY, LL.B.

The 1960 Legislature of New York State was in regular session somewhat longer than in recent years. It convened on January 6, 1960 and adjourned sine die at approximately 1:30 a.m. on April 1, 1960. In all, 8,662 bills were introduced in the two houses; but with many amendments, some of which practically constituted new bills, the total of printed bills reached 10,250. At no other session of the legislature in the last decade was there such a high degree of activity concerning the Department of Mental Hygiene and mental health matters. While the number of bills on mental hygiene matters was unusually high (some 50 bills amending the Mental Hygiene Law and an equal number affecting interests of the department), those that passed the legislature and were sent to the governor for approval were not much above normal—some 14 bills amending the Mental Hygiene Law and a lesser number of related laws.

The department's legislative program, submitted to the 1960 session of the legislature, contained 11 bills which passed and became law and two which were killed in legislative committees. The two that were killed in committee have been in the department's legislative program for three or more years and have been killed by legislative committees each year.

APPROPRIATIONS

The 1960 legislature appropriated a total of \$246,645,387 to the department and its institutions for the fiscal year beginning April 1, 1960. The table illustrates a comparison of budget appropriations for the fiscal years 1959-1960 and 1960-61.

The decrease in the budget appropriations to the department and the institutions for the current fiscal year of \$9,799, 099 below the appropriation for the previous fiscal year is explained in part by the following excerpts from the memorandum of Commissioner Paul H. Hoch, M.D., to the director of the budget and to the leaders of the legislature when submitting the budget requests for the current year:

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Comparison of Department of Mental Hygiene Appropriations for 1959-60 and 1960-61

<i>Administration</i>	Appropriated 1959-60	Appropriated 1960-61	Increase	Decrease
Personal service	\$ 1,660,586	\$ 1,693,958	\$ 33,372	
Maintenance and operation	457,652	394,964		\$ 62,688
Equipment	12,606	7,869		4,737
Total	\$ 2,130,844	\$ 2,096,791		\$ 34,053
<i>Institutional Operations</i>				
*Personal service	\$157,729,327	\$158,290,813	\$ 561,486	
*Maintenance and operation	39,417,871	39,582,902	165,031	
Maintenance undistributed				
Iroquois Annex (Gowanda)	282,000	284,814	2,814	
Sampson Annex (Willard)	198,252	793,008	594,756	
Improving patient facilities (Wassaic)	123,717	131,681	7,964	
S and E,** including the staffing of new facilities..	208,383	49,448		158,935
Aftercare clinics	1,582,692	1,618,065	35,373	
Intensive treatment, chronic	366,049	394,185	28,136	
Day hospital services	164,519	169,319	4,800	
Antibiotics for T.B.	30,000	30,000		
Tranquilizing drugs	2,350,000	2,500,000	150,000	
Equipment	1,329,894	1,695,281	365,387	
Total	\$203,782,704	\$205,539,516	\$1,756,812	

*Includes only 50 per cent of total appropriations for New York State Psychiatric Institute and Syracuse Psychiatric Hospital.

**Salaries and expenses.

Research and Special Studies

Epidemiological research unit	\$ 149,531	\$ 139,967		\$ 9,564
Biometrics research unit ..	53,970	55,642	\$ 1,672	
Psychiatric guidance to aged	109,136	91,716		17,420
Study of problems relating to alcoholism	121,825	115,000		6,825
Studies for emotionally dis- turbed children	60,000	60,000		
Counselling and community centers for mentally re- tarded children	260,000	232,500		27,500
Institutional research projects	1,446,470	1,446,470		
*N.Y.S. Psychiatric Institute	1,026,617	1,049,341	22,724	
Total	\$ 3,227,549	\$ 3,190,636		\$ 36,913

*Represents 50 per cent of total appropriation for New York State Psychiatric Institute.

Comparison of Department of Mental Hygiene Appropriations for 1959-60 and 1960-61
(continued)

<i>Training and Education</i>	Appropriated 1959-60	Appropriated 1960-61	Increase	Decrease
Tuitions, stipends, fellow- ships	\$ 198,000	\$ 160,000		38,000
Training of medical staff..	350,000	350,000		
*Syracuse Psychiatric Hospital	251,835	262,455	\$ 10,620	
Total	\$ 799,835	\$ 772,455		27,380

*Represents 50 per cent of Syracuse Psychiatric Hospital's total appropriation.

<i>Programs</i>				
Child guidance clinics	\$ 425,162	\$ 341,065		\$ 84,097
Psychiatric services to cor- rectional institutions	356,538	331,440		25,098
Mental Hygiene Council...	16,600	16,025		575
Assistance in obtaining em- ployment for former pts.	10,840	—0—		10,840
Rehabilitation of senile patients	159,193	164,474	5,281	
Community care	2,664,740	2,789,800	125,060	
Total	\$ 3,633,073	\$ 3,642,804	\$ 9,731	
Total State Purposes Fund.	\$213,574,005	\$215,242,202	\$1,668,197	
<i>General State Charges</i>				
State Hospital Retirement Fund	\$ 669,783	\$ 669,783		
<i>Local Assistance Fund</i>				
Community Mental Health Services	\$ 11,500,000	\$ 11,500,000		
Administration of commu- nity mental health program	304,698	211,402		93,296
Total	\$ 11,804,698	\$ 11,711,402		93,296
<i>Capital Construction Fund</i>				
Capital projects	\$ 29,255,000	\$ 17,752,000		\$11,503,000
Rehabilitation and improve- ments	900,000	900,000		
First instance appropriations	241,000	370,000	129,000	

Comparison of Department of Mental Hygiene Appropriations for 1959-60 and 1960-61
(concluded)

	Appropriated 1959-60	Appropriated 1960-61	Increase	Decrease
Brooklyn State Hospital, clinical research facilities	(241,000)			
Manhattan State Hospital, Research laboratory-nar- cotic addiction		(300,000)		
Middletown State Hospital, swimming pool-A. F. Wal- lace Fund		(70,000)		
Total	\$ 30,396,000	\$ 19,022,000		\$11,374,000
Grand totals	\$256,444,486	\$246,645,387		\$ 9,799,099

"Cognizant of the financial situation affecting the state and Governor Rockefeller's directive that the state budget for 1960-61 shall be kept within the limits of the current budget, we have given serious and thoughtful consideration to the problems affecting this Department. On the whole, we have prepared a budget request that we believe meets the requirements in this respect.

"We have reviewed our program and its cost; we have withheld requesting funds for new proposals and we believe that the budget we have submitted is to all intents and purposes the minimum request required for our operation.

"The admission rate of patients admitted to the state hospitals has increased by 26 per cent during the past years... We have been able to provide treatment and reduce greatly the term of hospitalization for many patients. Regardless of this, the high admission rate is gradually catching up with our releases and the favorable margin is being reduced...

"For the next year then we estimate our census at 113,640, the same as for the current year but with a net reduction of 500 in state hospitals and an increase of 500 in state schools."

On March 7, 1960, the governor delivered a special message on mental health to the legislature. It contained significant statements of policy affecting the budget:

"For more than half a century the care of the mentally disabled has been a major concern of State government. Today it accounts for one-third of our State Purposes Budget. In years

past the emphasis was necessarily on providing custodial care. More recently, your Honorable Bodies, by your forward looking action, have lent strong support to the development of more affirmative methods for the promotion of mental health.

"The problem of care for the mentally disabled was one of overwhelming proportions, with a constantly rising number of hospital patients. The quest for new methods and new treatments, large scale experiments with new drugs and other new therapies have, however, produced gratifying results in our State Hospitals.

"By the end of 1954 drug therapy was adopted for general use in our hospitals and by July, 1955, the turning point was reached—for the first time in their history the populations of our mental hospitals began to decline.

"It is nonetheless significant that while our mental hospital populations are now declining admissions continue to rise. The current admission rate is 26 per cent higher than in 1955. General population growth has contributed to this, but increasing public confidence in the treatment given by our State hospitals has undoubtedly been a very large contributing factor. Through more rapid and effective methods of treatment we have fortunately been able to absorb this increase and now accommodate all the additional patients with 4 per cent fewer beds. The challenge, however, remains great. We dare not permit our support to falter.

"The problem of caring for the mentally retarded is among our most difficult concerns. The new treatment methods which have proved so successful for the mentally ill have no effect on mental deficiency. While the populations of State hospitals for the mentally ill have begun to decline the populations of State schools for mentally retarded have risen at a rapid rate and overcrowding is becoming increasingly serious. The planned use of facilities at Mount McGregor as an annex to the Rome State School is but one way in which the Administration is seeking to meet this urgent need for additional accommodations.

"Today the battle against mental disability is being waged on three fronts—in the community, in State institutions, and in research laboratories. In each of these three areas there are certain measures which should be undertaken now to solidify the advances we have made and to insure further progress."

Some excerpts from the message of the governor to the legislature at the time he presented the executive budget cast a revealing light upon appropriations to the department and future responsibilities and activities of the department. The governor said, "The conversion of the Mt. McGregor Rest Camp in Saratoga County to an annex of the Rome State School for the mentally retarded is necessary if we are to meet the rapidly expanding need for such facilities. This will result in a saving in 1960-61 during the transition period of \$787,000 and at the same time make it possible for us to repeal a Capital Construction Fund appropriation of \$1.5 million for a new patient building which we had anticipated erecting at Rome."

The governor further said, "The conversion of the New York Woman's Relief Corps Home at Oxford in Chenango County to an annex of the Binghamton State Hospital is clearly justified. For some time we have had appropriations for the modernization of older buildings which are structurally sound at the Binghamton State Hospital. We have, however, not had available space into which we could move the patients while the rehabilitation took place."

Elsewhere in his message, the governor said, "Closing nine of our most unprofitable institution farms is clearly indicated. Farms at Auburn Prison, the Warwick Training School, the Mt. McGregor Rest Camp, Letchworth Village, Wassaic State School and the four farms at Binghamton, Hudson River, Harlem Valley and St. Lawrence State Hospitals are recommended for termination. The State will save approximately \$578,000 in 1960-61 even after allowing for the produce which they might furnish for use in our institutions. At one time our farms served a useful purpose in providing therapeutic experience for institutional patients. For the most part, this is no longer recommended and the State finds itself in the unfortunate position of being unable to operate the farms at a profit. Even after these nine are closed, we shall still have 30 farms which will receive our further careful study. Those which continue to prove unprofitable will be recommended for termination in the future unless they serve a useful therapeutic or training purpose."

Concerning capital construction projects for the Department of Mental Hygiene, the governor had the following to say:

"During 1959 we have initiated surveys and will shortly acquire three sites for new mental health institutions. These sites are at Fresh Creek in Brooklyn and the Town of Huntington in Suffolk County for new schools, and a site at South Beach on Staten Island for a new hospital.

"Among the significant items recommended in the 1960-61 budget are:

	Millions
Auditorium and chapel—Bronx State Hospital	\$1.0
Laundry building—Newark State School	0.7
Medical Surgical Building—West Seneca State School .	3.0
Infants' building (180 patients)—West Seneca State School	0.9
Cafeteria and kitchen—West Seneca State School	0.5
Patients' buildings (240 patients)—West Seneca State School	2.0
Special treatment building (90 patients)—West Seneca State School	0.8
School and assembly building—West Seneca State School	2.0

"Contracts have been let during the past year for additional buildings at the new Bronx State Hospital and at the new school at West Seneca in Erie County."

MENTAL HYGIENE LAW

Department Program Bills

Chapter 23 of the Laws of 1960 amends Section 34, subdivision 14 of the Mental Hygiene Law to increase from \$1,000 to \$2,500 the amount of a patient's funds which the director may receive and administer for the benefit of the patient. The changing value of the dollar and the savings to patients by having their funds administered at the institution without the appointment of a committee dictated the necessity for this legislation.

Chapter 60 of the Laws of 1960 corrects an ambiguity in subdivision 3 of Section 81 of the Mental Hygiene Law, which was caused by the enactment during the 1959 session of two separate amendments of that subdivision. These two separate laws, enacted in 1959, were integrated and combined by this enactment.

Chapter 61 of the Laws of 1960 amends Section 72 of the Mental Hygiene Law to insert the term "mental illness" for the anomalous

term "mental derangement other than drug addiction or drunkenness." The former language was ambiguous and archaic. The removal of the reference to drug addiction is also consistent with legislation later discussed herein providing for admission of non-psychotic drug addicts to the state institutions.

Chapter 511 of the Laws of 1960 amends several sections of the Mental Hygiene Law, eliminating the requirement that institutions in the department file copies of certification papers in the department. This will result in a monetary savings to the state and will eliminate duplication of the filing of information with the department, since statistical reporting by the institutions to the department includes all of the essential information from the commitment papers.

Chapter 529 of the Laws of 1960 adds a new Section 201-a to the Mental Hygiene Law providing for the certification of non-psychotic drug addicts to an institution in the department certified by the commissioner as having special facilities for care, treatment and study of narcotic addicts. In approving this legislation and at the same time Chapter 530 of the Laws of 1960 (not a program bill but having departmental approval), the governor had the following to say:

"These two bills constitute the most important steps ever taken by our State to deal with the tragic human problem of narcotic addiction.

"Admission and detention procedure for narcotic addicts. The first bill (Assembly Bill, Introductory Number 1287) is the product of the administration's interdepartmental study of narcotic addiction. It provides a legal basis for the admission and detention for not more than twelve months of a drug addict in any State hospital having special facilities for the care and treatment of narcotic addicts. This bill was most carefully drawn to protect the legal rights of the individual and was amended after introduction to provide further protections.

"We are faced with the problem of a drug addict, who is beginning to benefit from the care and treatment provided by the State at its new facility at Manhattan State Hospital, prematurely leaving the hospital. There is at present no basis whereby he can be legally restrained until such time as there are grounds to believe that permanent rehabilitation has been achieved. This bill will permit the Department of Mental Hygiene to use all the

modern methods known to medical science to attempt to effect a lasting cure for an individual suffering from drug addiction.

"The 1960-61 Budget for the Manhattan State Hospital Research Project. There is included in my budget for the current fiscal year \$870,000 for construction of new narcotic addiction research facilities at Manhattan State Hospital and an additional \$181,000 for the operating expenses of this research program. This will provide special facilities for one hundred fifty outpatients and fifty-five inpatients participating in the research project.

"New facilities for care of narcotic addicts. This second bill (Senate Bill, Introductory Number 3175) provides for the establishment of facilities for the care, treatment, cure and rehabilitation of drug addicts. It appropriates \$300,000 to implement this program during the fiscal year 1960-61.

"With over 20,000 persons in New York City suffering from the scourge of drug addiction, and with the population of our state mental hospitals finally beginning to decline, it is only appropriate that the State turn its attention to this tragic problem. We must not lessen our efforts to find an effective and permanent cure for drug addiction through intensive research. Such efforts hold the only real promise that this terrible evil can be finally stamped out. We cannot wait, however, until such a cure is discovered. This event may not take place for years to come. Our conscience dictates that we must do something immediately to care for and attempt to cure, with the admittedly inadequate means at our disposal, those addicts who would otherwise be wandering our streets, often committing crimes to obtain money to satisfy their craving.

"These bills, with our budget provisions for the fiscal year 1960-61, will permit us to deal with a problem of tremendous importance to the people of our State, a problem that must no longer be ignored.

"The bills are approved."

Chapter 854 of the Laws of 1960 adds a new Section 73-a to the Mental Hygiene Law providing for admission of persons to a mental institution upon the certificate of two physicians. This bill was part of the department's legislative program but was introduced by the governor at the time that he delivered a special message on mental health to the legislature on March 7, 1960 in which he said:

"The grim institutional fortress with locked doors and regimentation of patients is giving way to a new type of institutional care in New York. Today, except for the comparatively small number who require close supervision, mental patients are free to come and go within the institution grounds, choose their activities, their companions, and even their clothes.

"With modern treatment methods, open wards and an enlightened community attitude, the mental hospital is regarded less as a place of incarceration and better understood as a medical center for treatment of mental distase. Now, to a substantial degree, the mentally ill and their families themselves seek this treatment.

"Admission to a mental hospital should be no less a medical matter than admission to a general hospital. The Public's growing acceptance of this fact is reflected in the rapidly increasing proportion of voluntary admissions. As recently as five years ago fewer than 7 per cent of the patients entered State hospitals on a voluntary basis; today 30 per cent use a voluntary procedure.

"To effect a greater emphasis on the medical nature of such hospitalization and to remove it as much as reasonably possible from the stigma and potential traumatic effect of court proceedings, I recommend for your favorable action legislation submitted with this message which would permit admission to a mental hospital on the certificate of two physicians. This proposed legislation, developed in consultation with members of the judiciary and representatives of the bar, would require that at least one of the physicians be a psychiatrist and that the petition be made by a member of the family. It would further provide that if the patient thereafter wishes to leave the institution and the director feels that he should be detained for further treatment, the matter would at that time be referred to the court.

"Such an arrangement emphasizes the medical nature of hospitalization procedures, preserves the Constitutional rights of the patient and provides any necessary protection to society at large."

Chapter 869 of the Laws of 1960 amends Section 202 of the Mental Hygiene Law to permit the treatment of mental patients in a "community residence" having a rehabilitative program for the care and treatment of the mentally ill admitted directly thereto or received from a state or licensed institution and maintaining adequate staff and facilities for such purposes approved by the

commissioner of mental hygiene. Governor Rockefeller stated in his memorandum of approval of this legislation:

"This bill, sponsored by the administration, would permit the treatment of mental patients in 'community residences' having a rehabilitative program for the care and treatment of the mentally ill and maintaining adequate staff and facilities for such purpose. Such residences would have to be approved by the Commissioner of Mental Hygiene.

"The bill implements the Department of Mental Hygiene's policy of treating mental patients as frequently as possible in a community setting. Patients not requiring treatment in a mental institution may, under this bill, be treated in a community residence or 'half-way house.'

"A great many mental patients can and should be treated in the community. This bill properly recognizes this fact and permits the establishment of one type of suitable facility in the community under appropriate supervision by the Commissioner of Mental Hygiene.

"The bill is approved."

Included in the department's program bills, proposing amendments to the Mental Hygiene Law, was one bill which was a reintroduction of a bill included in the department's program in previous years. The bill proposed to redesignate the state schools in the department with the exception of Syracuse State School and Letchworth Village as "_____ School and Hospital." This bill is the same as bills approved for introduction by the present governor and the previous governor, with the exception that the word "State" in the title of the schools would have been eliminated by the bill introduced at the last session of the legislature. The same opponents of the previous bills defeated the bill again.

Bills Not Sponsored by the Department

Chapter 147 of the Laws of 1960 amends Section 5 of the Mental Hygiene Law, deleting the provisions relating to waiver of citizenship requirements. This provision is contained in the Civil Service Law, and the Civil Service Department deemed it desirable to remove the duplicate provision found in the Mental Hygiene Law, as well as in several other of the codified laws.

Chapter 338 of the Laws of 1960 amends the Mental Hygiene Law, adding a new Section 176-a increasing the take-home pay

for the current fiscal year of state employees in the State Hospital Retirement System under the same principle that is applicable to other state employees, by which the State pays up to the first 5 per cent of the employees' contributions to the Retirement System.

Chapter 418 of the Laws of 1960 amends Section 191-a of the Mental Hygiene Law, increasing the 50 per cent reimbursement to localities of their expenditures for community mental health from a limit of \$1 per capita to \$1.20 per capita of the population of the locality. The department has recognized the need for raising the ceiling on reimbursement to localities under the Community Mental Health Services Act and has made or approved various suggestions as to methods of doing this. The administration has not found it fiscally feasible to increase such reimbursement until this year.

Chapter 530 of the Laws of 1960 adds a new Section 10-c to the Mental Hygiene Law authorizing the commissioner to establish, in one or more of the state hospitals, wings or wards or separate hospitals for the study, care, treatment, cure and rehabilitation of drug addicts who are admitted as voluntary patients or pursuant to court certification as provided in Section 201-a of the Mental Hygiene Law. This bill carried an appropriation of \$300,000 for the department to carry out its provisions. The remarks of Governor Rockefeller on approving the bill are quoted in the foregoing in connection with the department's program bill which became Chapter 529 of the Laws of 1960.

Chapter 847 of the Laws of 1960 amends Section 30 of the Mental Hygiene Law to increase from seven to eight the number of members of the board of visitors of Willowbrook State School. This bill did not have the approval of the department.

One bill which did not become law and which proposed an amendment to the Mental Hygiene Law should be mentioned here. Governor Rockefeller introduced legislation in connection with his mental health message, excerpts concerning which follow:

"A Long-range Research Plan. Psychiatric research into all areas of human behavior is no longer a minor function of the science of mental health. It is an integral part of the total approach to the problem of mental illness. The past success of our State's mental health research program encourages us to push ahead with new lines of investigation, but in so doing the Depart-

ment of Mental Hygiene with a broad program of research should take steps to integrate its research activities into a comprehensive long-range plan. To this end I am recommending legislation submitted with this message providing for the appointment of a research council to advise the Department of Mental Hygiene on research policies. The objective of the council will be to assist in bringing into focus the overall research aims of the Department and to define the relationship of each operating unit to the whole research program. Such a council would stimulate the essential exchange among the scientists engaged in the various areas of research and provide for the widest possible application of information developed as the result of research.

"As a part of this coordination of research activity, this bill which I am submitting with this message would also provide for a Research Article within the Mental Hygiene Law in which provisions relating to research would be brought together. I urge your support for this proposed legislation to furnish new emphasis on research in the field of mental health and to help maintain New York's position as a leader in the field of mental health.

"It is a sobering fact to be remembered that one person in every ten suffers from a mental or emotional disturbance serious enough to require treatment."

The bill concerning research was amended by members of the legislature to provide that the chairmen of the standing committees on public health of both houses would be ex officio members of the research council. The governor felt that this would raise a constitutional question of the improper mingling of the executive and legislative branches of the government, and he therefore vetoed the bill.

OTHER BILLS RELATING TO MENTAL HYGIENE

Department Program Bills

Chapter 75 of the Laws of 1960 amends Section 872 of the Code of Criminal Procedure, providing that wherever the district attorney has not filed an information or presented evidence to a grand jury in connection with a defendant who has been committed to a mental institution pursuant to that section within two years from the date of his commitment, and he states in writing that he does not intend to file an information or present evidence against the defendant to a grand jury, he may not thereafter do so.

Chapter 550 of the Laws of 1960 amends Section 454 of the Code of Criminal Procedure relating to the disposition of a defendant who has been acquitted of crime on the grounds of insanity.

Governor Rockefeller when he signed this legislation into law wrote the following memorandum of approval:

"A new procedure for the commitment of persons acquitted on the ground of insanity. The third bill with which this memorandum is filed changes the procedure for defendants following acquittal on the ground of insanity. Such acquittals usually occur in cases where a defendant has acted in a way which threatened serious danger or injury to the public. Even though the perpetrator may not be morally responsible for his act, the public has a vital concern in any procedure for the release of such persons. This procedure should at the same time be consistent with accepted advances in psychiatric knowledge and technique. At present, the commitment of an acquitted defendant to a mental institution lies in the discretion of the court. The only test for release is 'recovery'. This bill would:

"(1) Mandate the commitment to a mental institution of any defendants acquitted by reason of insanity;

"(2) Thereafter permit the release from the institution of any such person by the court upon competent psychiatric evidence that he no longer is a danger to himself or to others;

"(3) Alternatively, permit the conditional release from the institution of any such person who is not a danger to himself or to others but who requires further psychiatric treatment; and

"(4) Establish a more precise procedure by which a person can apply to the court for his release.

"While this change in procedure following acquittal on the ground of insanity represents a significant improvement in the handling of insanity in relation to criminal law, much remains to be done to conform the criminal law to modern psychiatric knowledge including the test of insanity in criminal cases. This is a task for the year ahead."

A bill in the department's program which has been re-introduced several years, again failed of passage this year. It would permit a patient who had been judicially certified to an institution and

released, but not as recovered, to register and vote if the head of the institution certified that his mental condition warranted his proper exercise of his right to vote. It would also have repealed the provision added to the Election Law several years ago to require the court to notify the election board of the adjudication of a person as an incompetent and to require the institution director to notify the election board as to all persons duly certified to the institution.

Bills Not Sponsored by the Department

Chapter 9 of the Laws of 1960 authorizes the State Board of Land Commissioners with the consent of the commissioner of mental hygiene to release certain lands of Utica State Hospital to Utica Lodge of Elks.

Chapter 176 of the Laws of 1960 authorizes the State Board of Land Commissioners to release certain lands of Utica State Hospital, previously conveyed to the Utica College Foundation, from the reverter conditions contained in the letters patent, upon payment of the appropriate consideration.

Chapter 437 of the Laws of 1960 authorizes the State Board of Land Commissioners to convey certain lands of Binghamton State Hospital to an organization entitled "New Industries for Binghamton, Inc." Governor Rockefeller, in approving this bill, said "This measure is entirely in accord with the goal of this Administration to provide more and better job opportunities through economic growth and an improved business climate."

Chapter 654 of the Laws of 1960 authorizes the State Board of Land Commissioners to sell and convey with the consent of the commissioner to the Town of Kirkwood for recreational facilities certain lands of Binghamton State Hospital.

Chapter 1070 of the Laws of 1960 authorizes the State Board of Land Commissioners with the consent of the commissioner of mental hygiene and approval of the budget director to grant to the Ogdensburg Port Authority certain lands of St. Lawrence State Hospital.

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EDITORIAL COMMENT

BETTER LEFT UNSAID

Sometimes, all of us being human, scientists talk too much. Scientists include psychiatrists and psychologists—who now and then discourse too publicly and too glibly about matters their hearers promptly misunderstand. These include such things as prognosis and diagnosis, personality profiles and personality dynamics, projective tests and IQ's, the last of which, totaled from discrete bits of raw data, are at times deceptively simple and at times simply deceptive.

All scientists are concerned with the knowledge that if our democratic society, or perhaps even our human species, is to survive in this atomic age, there must not only be scientific freedom, but the spread of all scientific knowledge possible to all mankind. But because human life is short, (and because we have not yet returned to Methuselah) no man can now comprehend all of human knowledge—or even comprehend even a little about everything that is known.

The IQ is not fully understood by the scientific specialists who determine it and make use of it—psychologists, psychiatrists, educators, counselors—and who do not always employ it profitably themselves. This journal, therefore, thinks it proper to express concern over the recent decision* of New York State educational authorities to disclose IQ's and similar data, when requested, to parents who are certain to misunderstand and misuse them.

In fairness, it should be noted that the education department's ruling was handed down after a great deal of pressure and that it was circulated to the local school departments, accompanied by a detailed directive that a school must make sure, in giving IQ or similar data to a parent, "that the information is understandable and useful to the parent in the interests of the child's development through education." The ruling itself states that "appropriate personnel should be present where necessary to prevent any misinterpretation by the parent of the meaning of the record..."

But what can "appropriate" or any other personnel do to make information understandable and useful and prevent misinterpre-

*In September 1960.

tation when a parent is already convinced wrongly that he already understands, that he knows what to do, and that he is interpreting correctly? The medical profession has labored largely in vain for at least two generations in attempting to convince the public that the common cold is not caused primarily by getting wet feet or sitting in a cold draft. This journal agrees with the Council of School Superintendents, Cities and Villages of the State of New York that a board of education should have the right to require interpretation only of school records to parents by "qualified personnel without actual inspection by people in a parental position," and agrees that if this is against existing law, the law might well be amended.*

The IQ is a measure, or rather a scale for the measurement, of certain mental characteristics or capabilities, but nobody is quite certain exactly what those characteristics or capabilities are. One of the first things emphasized to the beginning student of psychology is that the IQ is not an exact measure of inherited and permanently fixed capacity for achievement—although many nonspecialists believe that is precisely what it is. It is certainly a measure; and it appears, from present evidence, to be an approximate measure of a subject's ability at the time of testing to succeed at most academic subjects. One presumes that this ability involves many factors, both inherited and acquired from environment; we are not at all sure exactly what factors are measured, and we have no complete assurance that we are using the appropriate scales.

The apparent IQ can be a figure depressed by neurosis; the IQ can be raised—though the extent and effectiveness of the process is debatable—by appropriate manipulation of environment; the IQ is never entirely independent, despite much effort in the construction of special scales, from the effects of literacy and general education and from those of such things as familiarity or the lack of it with the language of test administration.

These are all drawbacks, even if one assumes that capacity for academic success or success in life is actually being measured. They affect the result, regardless of what is being measured. But there are matters that lead one to question, today more than ever, just how successful the test-makers have been in devising measures to

*Resolution adopted at Albany meeting of the Council of School Superintendents, Albany. December 9, 1960.

test actual ability—whatever that may be—or to forecast the successful employment of ability.

It seems fairly plain, for one thing, that today's intelligence tests are not well adapted to the detection or the appraisal of certain special abilities—in mathematics, for example, in music, in the fine arts, and in such skills as oratory—in all of which high capability does not necessarily correlate with high IQ. In the range of mathematical prodigies or phenomenal mental calculators, from Jedediah Buxton to Ampère and Gauss, there are estimates of general intelligence from mental defect to genius, or in modern terms from IQ's of 80 or less to 150 or more.* These people have been the subject of much psychological speculation and little intensive psychological study; few modern lightning calculators seem to have needed psychiatric treatment. But most of them appear to have led satisfactory lives, and many, even of the concededly unintelligent among them, have won general respect for achievement and usefulness. The IQ would have forecast failure for many of these, and not many psychologists would contend that the IQ is adapted to show the existence of faculties of their sort.

This observation holds true of the chess prodigy as well, and of the prodigy in fine arts or music. Thus, there is a wide range of activities in which there is no necessarily direct relationship between high IQ and successful accomplishment in life. This observation, of course, applies also to special abilities which are neither in the classification of great talent nor in that of genius. Many persons of moderate specialized capabilities have had successful, useful and presumably satisfactory lives as professional musicians, portrait painters and landscape architects, for example, without necessarily having high IQ's. The professional who pronounces that a child's capacities for a full life are limited by a not-too-high IQ, and the parent who believes him, are ignorant or unmindful of a wide range of socially-useful capacities which the intelligence test does not reflect.

Another consideration, reflected in the construction of the Wechsler and some other intelligence tests but seldom accorded due significance, is Bergson's differentiation of *Homo sapiens* and *Homo faber*, man with the intelligence of classical logic and psy-

*Ball, W. W. Rouse: *Calculating prodigies*. In: *The World of Mathematics*. Vol. 1, p. 467. James R. Newman, editor. Simon and Schuster. New York. 1956.
Barlow, Fred: *Mathematical Prodigies*. Philosophical Library. New York. 1952.

chology, and man with practical technological intelligence. Gaston Viaud presents a short and stimulating review of the question, which seems well worth while as a reminder to professionals as well as a contribution to general public knowledge of science.* It is a question whether man the maker has not contributed as much to the long and painful progress of the race as man the thinker. Viaud points out contrasting periods in history in which man the thinker and man the maker dominated in turn, and raises the question of whether we are not now entering a technological age, where "practical man" will assume the importance held by "theoretical man" in our own phase of civilization. Even Wechsler's efforts to balance *Homo faber* against *Homo sapiens* in his testing leave much to be desired in the way of disclosing "practical" skill and ability. They do not, for example, disclose ability to invent or to adapt the tools of civilization, or disclose the possession of abilities required for instrument-making, diamond-cutting, the creating of *haute cuisine*, or the performance of innumerable other socially valuable tasks. With attainment in many of these, the IQ as now determined does not correlate too usefully.

The professional user can think readily of numerous other factors qualifying the use of the IQ as a practical measurement. One of them is brought out in an extraordinary study, employing the "Denny Doodlebug,"** and directed by Milton Rokeach at Michigan State University.† Rokeach and his colleagues investigated the effects of dogmatism and rigidity as contrasted with their lack (the "closed" versus the "open" mind) on capacity to deal with new situations. Their subjects were members of college psychology classes, and the general adequacy and general comparability of their IQ's, according to conventional standards, is not in question. But their adequacy as problem-solvers showed marked differences, according to whether they had "closed" or "open" minds, a matter of concern both to *Homo sapiens* and *Homo faber*.

The Michigan State tests deal extensively with the private worlds of Denny's doodlebug, christened "Joe Doodlebug" for the occasion. In a given cosmos, Joe moves according to carefully laid down rules and regulations, and the subjects solve problems based

*Viaud, Gaston: *Intelligence: its evolution and forms*. Science Today Series. Harper. New York. 1960.

**Named for its inventor, M. Ray Denny, Ph.D.

†Rokeach, Milton: *The Open and Closed Mind. Investigation into the Nature of Belief Systems and Personality Systems*. Basic Books. New York. 1960.

on the natural laws of the world Joe lives in. Then the rules governing Joe's moves are changed; it is as if he were another creature in a new cosmos. Or the chessplayer might imagine, if he prefers, that, according to new rules of the game, the rook can now move only three squares at a time, the bishop must change directions by turning at an angle in the middle of each move, the queen has the added power of moving like a knight, and the king can jump other pieces like a checker.

Rokeach's students showed group differences, even in solving Joe's original problem; and when Joe was placed by new rules in a new cosmos, the students judged by previous tests to be closed-minded had much more trouble adjusting to the new situation than the group adjudged to be open-minded. The trend seemed well-established; and it is permissible for a commentator to wonder—although these tests need not be regarded as conclusive—if differences between open and closed minds do not have more effect than is generally recognized in determining why two students with identical ability for accomplishment, according to IQ, may differ markedly in actual accomplishment reached. The generally-used tests of IQ stress ability to solve problems, but it may now be wondered if they stress it enough, and if they account at all adequately for such things as open-mind versus closed-mind factors.

This discussion is superficial. The psychologist and the psychiatrist are well aware of most of the points discussed, which are limited, except for mention of neurosis, to matters in the domain of the ego or the intellect—certainly to the sphere of the conscious. The educational and vocational counselor is also certainly well aware of the possibilities for useful and satisfying accomplishment for many of those with less than upper-bracket IQ's. But the parent who regards the IQ as a decree of fate is not so aware, and many of us who know better often talk and act as if we also were not aware.

Besides the psychologist and psychiatrist, many educators seem fully awake to the dangers of lay knowledge of the IQ without ability to interpret it. A newspaper report by John Corey, writer for Phi Delta Kappa, which has been widely publicized by that educational fraternity,* cites some pungent opinions held by Dr. J. A. R. Wilson, professor of education at the University of Calif-

*Organization of American educators, with headquarters in Bloomington, Ind.

ornia at Santa Barbara. Professor Wilson notes that drive, willingness to work hard, ambition, belief in one's vocation, good appearance, moral character and social insight (for all of which those so inclined may substitute appropriate professional jargon) usually outweigh an advantage in IQ in attaining success in life. He remarks, as has already been said here, that there is little relation between IQ and many kinds of success in life. Other educators have met parental demands for information—with which one may fully sympathize—by interpreting test results rather than giving scores, thus making sure that parents understand them.*

No reasonable or responsible person would attempt to prevent a parent from obtaining all usable information relevant to the success or happiness of a child. We have child guidance clinics, in fact, for the principal purpose of giving parents such information, coupled with advice and therapy in cases of markedly disturbed children. Those clinics, however, take precautions to see that the information given is understood and so is unlikely to be misused. Nobody could object to disclosure of carefully screened information by the schools, if such precautions were taken.

It should be noted that specialized psychological data in the wrong hands can be misused by other than parents. In a widely publicized action in the early part of 1960, the New Jersey Board of Child Welfare moved to remove a four-year-old child from a foster home where she was greatly loved, on the grounds that her IQ of 138 made her too bright for her foster parents' economic and cultural status. The case reached the courts before the welfare board reversed itself and thus averted an emotional trauma of no mean proportions.** It apparently had not occurred to the board that the IQ was an isolated datum; that other factors in the little girl's case called for as great or greater consideration; and that, in the ordinary course of events, children with exceptionally high IQ's are often born (or sometimes adopted) into ordinary families—a situation inherent in the very meaning of exceptional.

It is by no means uncommon to hear of instances where a man's fate has been decided on the basis of one or two points of IQ. Let the psychologist come up with a score of 71 and a man may be adjudged intelligent enough to stand trial, for murder for

*Interview with Theodore F. Reusswig, superintendent of schools, Utica, N. Y., in *Utica Observer-Dispatch*, October 4, 1960.

***New York Herald-Tribune*, March 9 and March 16, 1960.

instance, even though this score may have been attained only by virtue of a disproportionately high performance IQ, which has little or no bearing on an individual's ability to understand a charge against him or make his defense; these call for purely verbal skills. On the other hand, an IQ of 69, in some places, will automatically bring on a verdict that an individual cannot understand a charge or make his defense, or distinguish right from wrong, and he becomes a candidate for a state school or an institution for defective delinquents, rather than for prison or the electric chair. This is in spite of the fact that we are all aware that two different psychologists giving the same test to the same patient on the same day may easily come up with scores which will differ by 4 or 5 points, or more. To compound the felony further, there are certain jurisdictions where an IQ of 50 is considered sufficient to enable an individual to stand trial (based on the reasoning that he is neither idiot nor imbecile). At the other extreme, there are hundreds of individuals whose IQs range between 70 and 85, and in many instances even higher, who have been labeled mentally defective and placed in state schools, either for the convenience of some court or other agency, or because the parents cannot or will not care for them, and no other place is available.

There is a somewhat analogous situation to that of the IQ in general medicine, where—as every medical student knows—there are more reasons than historic accident for making a mystery to his patients of the doctor's prescription. It was probably an ill matter for the general progress of civilization, but a fortunate one for the progress of medicine, that, when the medieval leech first squiggled his cryptically-abbreviated mongrelized Latin formulae for the therapeutic dosages, the vast majority of mankind could not read them. It is still fortunate that all but a handful of literate moderns are still illiterate in the traditional gibberish of prescriptions. It takes five years or so of highly specialized post-collegiate education and supervised practice before a doctor is free to diagnose medical disorders and prescribe for them. Were the doctor to write out his orders in plain English, and were his doses obtainable without prescription, we would have many more patients than we now have who would assume they knew as much as their doctors, and tinker with their medications—often, as psychiatrists know—on the theory that if a doctor's dosage of anything from strychnine sulfate to a barbiturate is good for one, trip-

ling it makes it three times as good. There are cases, of course, where it is desirable for the patient to know what he is taking and why; but these are matters for the doctor's discretion.

It is the contention here that when and to whom information of the nature of IQ's is disclosed, should also be at the specialist's—the psychologist's or psychiatrist's or educator's—discretion. Unfortunately, it is impossible to reproduce the situation in which medical prescriptions were first set down; today's public thinks it understands what IQ numbers mean, and it would be impossible to conceal already-known facts by use of a code. It has been suggested that the IQ be renamed the AA (for academic aptitude)* and so become less misleading to nonspecialists when it does become known. Also, the author of this suggestion—who favors general disclosure of IQ's—advocates that a careful explanation of the meaning be supplied when the figures are given. It would be still better if, when tests of IQ, or aptitude, or achievement-possibility are improved, as they someday may be, by consideration of factors not now adequately accounted for, the scoring could be kept a matter of professional confidence—with discussion perhaps confined to professional publications. One would hardly advocate purposeful complications; but it might be well to consider the Rorschach, the scores of which could safely be broadcast all over the place with no danger of misunderstanding, for the non-professional cannot make head or tail of them. Even in our scientific civilization, there seem to be secret things that would best remain secret—under the sign and seal of Hermes Trismegistus.

*Suggestion by Henry Chauncy, head of a professional testing organization, as quoted in an article by John Corey.

BOOK REVIEWS

Scoring Human Motives: A Manual. By JOHN DOLLARD and FRANK AULD, JR. 452 pages. Cloth. Yale University Press. New Haven. 1959. Price \$9.50.

The reviewer found this book fascinating but is not at all sure that it is successful in the sense that the authors' purpose is realized. For what Dollard, the distinguished social scientist, and Auld, his erstwhile colleague at Yale, have attempted is a detailed content analysis of the therapeutic transaction—which would capture the significant aspects of that process at the same time that it reduced them to discrete, analytic, scorable categories. Anyone who has toyed with therapy protocols with such an aim vaguely in mind will applaud the authors' courage, admire the wealth of insight they bring to the task and almost surely grant that they have, at least partly, achieved their aim. Reservations, however, must be entered, because the scoring system, although highly reliable in the hands of well-trained psychologists (Dollard and Auld did all the scoring), has been subjected to very few validity studies. The authors recognize this drawback and point out that they were primarily interested in determining whether reliable measures could be developed. But they also point out, that "no one could have any interest in a reliable but useless system."

A "final" verdict (no verdicts in science are ever final) must wait not only upon more validity tests but additional reliability studies as well, for the scoring system is extremely detailed, and it will be interesting to learn how other scorers fare with it.

Whether or not one is interested in content analysis, this book will be found valuable for its rich examples of specific clinical concepts—such as conscious sexual motivation combined with unconscious anxiety, conscious fear of dependency and the like. For the teacher, there is a storehouse of useful illustrative materials; for the therapist, a valuable look at the way two gifted psychologists view the therapeutic process.

Freud and Dewey on the Nature of Man. By MORTON LEVITT. 180 pages including index. Cloth. Philosophical Library. New York. 1960. Price \$3.75.

Levitt sees correspondence in the views of Freud and Dewey on the nature of man, and points out in this book similarities in published statements of their views. He thinks Freud and Dewey paralleled and complemented each other, a view to which, this reviewer thinks, most Freudian psychoanalysts would take exception. Levitt's book is worth reading, if only for its unusual point of view.

The Seeker. By ALLEN WHEELIS. 242 pages. Cloth. Random House. New York. 1960. Price \$3.95.

This book is described as a novel by a psychoanalyst. It is not necessary that an analyst be a novelist, and this book apparently satisfies some need of the author, whether on the basis of an oral conflict, a displacement upward of an anal conflict, a guilt complex, or some other psychological mechanism. However, like most books concerning physicians and having a slight mixture of sex and taboos, this one will probably prove popular.

The Psychology of the Actor. By YOTI LANE. 224 pages. Cloth. John Day. New York. 1960. Price \$3.75.

Had Miss Lane's book confined itself to its first chapter, that is, to a sketch of the history of the acting profession, all might have been well. It is her attempt to analyze the psychology of the actor, that is far from successful. One is given to understand, throughout some 200 pages of not very good writing, that actors are invariably emotionally immature, and that, like the primitive being and the child, they have an immoderate and all-consuming love for praise and personal power. It would seem to the reviewer, that while exhibitionism may be usual in the profession, many of our finest actors and actresses could be considered thoughtful and mature people, who have achieved success through long and intelligent study in their chosen field. The reviewer found this book of little interest or use.

Psychological Techniques in Diagnosis and Evaluation. By T. C.

KAHN, Ph.D. and M. B. GIFFEN, M.D. 164 pages including index and illustrations. Cloth. Pergamon Press. New York. 1960. Price \$6.50.

The authors aim to bring a better understanding of the work of the clinical psychologist to people who are not well acquainted with this particular area and who in the course of their careers may have dealings with the psychologist and his reports. This book then is not primarily for psychologists, but is rather for lawyers, teachers, social workers, etc.

A book of this sort is certainly needed, but unfortunately this is not it. The authors too frequently lose sight of their intent. Material is presented without adequate explanation; there is a heavy reliance on the cook book "sign" approach for evaluation of psychopathology; and there are numerous references to Rorschach plates and TAT cards by number, without including illustrations of these particular tests or describing them in any adequate manner. Too often, much that is presented will have little meaning for people outside the profession.

This reviewer also objects to a poor editing—or maybe printing—job. Page 90 mentions "flattened effect," and there is a description of the Bender Visual Motor Gestalt Test on page 69 that is sure to make even the non-professional person question its correctness, let alone its adequacy.

The Mind of Man: A History of Psychotherapy and Psychoanalysis.

By WALTER BROMBERG, M.D. 344 pages. Paper. Harper. New York. Originally published in 1954, re-printed 1959. Price \$1.95.

In the preface to this edition, the author states, "Psychoanalytic training has become accepted as indispensable to those psychiatrists who utilize psychological principles in treatment." He later states in his preface that the eclectics in psychiatry who show tolerance for all theories are the hope of the profession. In spite of these apparently contradictory statements, the expansion of the original book and the history of psychiatric practice are well done. It is an easily readable text, which starts with magic and witchcraft and goes on to the early asylums, faith-healing, the beginning of modern science and psychological developments, and the beginnings of organic therapies. Unfortunately, the author has not brought the book up to date, and there is no mention of the newer drug therapies, the various aspects of social psychiatry in state hospitals, and the use of "open" hospitals as a therapeutic measure.

The author, as an analyst, devotes a good deal of time to analytic interpretations and study and overstates the place of analysis in modern psychiatry. He makes the same mistake that most authors do, holding that because analysis can explain some of the dynamic factors in schizophrenia, it plays a dominant part in treatment thereof. He fails to see or state the importance of all other forms of therapy and research in this tremendously important field.

However, because of its readability and coverage of the historical field in psychiatry, this book is well worth while in its present edition.

Child in the Shadows. A Manual for Parents of Retarded Children. By

EDWARD L. FRENCH, Ph.D. and J. CLIFFORD SCOTT, M.D. 156 pages. Cloth. Lippincott. Philadelphia. 1960. Price \$3.50.

This book will be welcomed by all those dealing with the problems of retarded children. It is written in dramatic and practical language, and gives the right answers to the questions that the parents of a retarded child are apt to ask.

The authors point out the pitfalls of negative attitudes; they urge a realistic and constructive point of view, and help parents to overcome the feelings of guilt so often linked to the problem. The aim is to assist parents and others to find the most promising ways and methods to guide the retarded child toward usefulness and happiness within the limit of his potential.

Child in the Shadows is highly recommended to all those wanting to understand and guide the intellectually retarded child from infancy to adulthood. The book is dedicated to Helen T. Devereux, pioneer in special education for the mentally retarded, and the founder of Devereux schools.

The Use of LSD in Psychotherapy: Transactions of a Conference on d-Lysergic Acid Diethylamid (LSD-25). HAROLD A. ABRAMSON, M.D., editor. 304 pages. Cloth. Josiah Macy, Jr., Foundation. New York. 1960. Price \$5.00.

There are contributions to this symposium from various related fields, including psychiatry, psychology, ethnology, and sociology. The purpose of the symposium is described as the free communication of ideas. Throughout the text, however, there are numerous diversions into semantics and the definition of terms. The experiments discussed involve few cases, and in most cases the results are subjective. The authors admit that in some cases similar results are obtained with placebos under the same so-called experimental conditions.

However, there is a fair amount of information here on the effects of LSD. Like all Macy symposiums, this one is well prepared and very readable.

Children of their Fathers. Growing up Among the Ngoni of Nyasaland. By MARGARET READ. 176 pages. Cloth. Yale University Press. New Haven. 1960. Price \$4.75.

This book presents the "growing up" of children of a native village in Central Africa. The child is brought up to conform to the personality pattern of Ngoni culture and society, with a conscious and direct control from birth through adolescence.

One may not agree with the principles of the Ngonis, but their positive approach may be of constructive interest to parents and educators. The Ngonis stress self-reliance, obedience, responsibility, sociability, dominance, and honor and respect for their elders.

The book is a valuable anthropological study in education and guidance. The author is professor of education and head of the department of education in tropical areas at the Institute of Education, University of London.

Basic Principles of Psychoanalysis. By A. A. BRILL, M.D. 318 pages including index. Paper. Washington Square Press. New York. 1960. Price 60 cents.

The first edition of this well-known book was published in 1921. The author had revised it, and he actually had the revised manuscript with him when he entered the hospital in 1948 for his brief final illness. The revision was finished by Philip R. Lehrman, M.D. From the date of its first publication, this book has been one of the most readable, informative and useful introductions to the principles of psychoanalysis. It is suitable for the educated layman as well as for the student of medicine. This low-priced edition is to be welcomed.

On The Balcony. By DAVID STACTON. 255 pages. Cloth. London House & Maxwell. New York. 1959. Price \$3.50.

A pseudo-sophisticated and cynical novel deals with Amenhotep IV, pharaoh of the eighteenth dynasty who, having ascended the throne in 1375 B.C., achieves the distinction of having created the first monotheistic religion. Changing his name (Ikhnaton), he dispossessed Amon, turning to Aton, the sun-god. That remarkable man became in 1912 the object of a famous study of the late Karl Abraham, one of the most distinguished members of Freud's old guard. Although Abraham's study (*Imago*, 1:334-360, 1912), based on Breasted's historical studies, certainly requires addenda to bring it to the level of today's knowledge, it is still high above what the reviewer considers to be the psychological nonsense and confusion Mr. Stacton dispenses. Religious fanaticism is not explained by a few mediocre jokes, nor is Queen Nefertiti's personality clarified by copying Shaw's Cleopatra.

Where The Boys Are. By GLENDON SWARTHOUT. 239 pages. Cloth. Random House. New York. 1960. Price \$3.50.

This is a novel about the college boys and girls who arrive en masse at Fort Lauderdale, Florida to spend their spring vacation. Mix collegiates, beach, beer, nightclubs, sex, throw in the Cuban rebellion for good measure. The author comes up from this combination with a series of very funny incidents. Recommended for those who enjoy light reading.

The Southern Heritage. By JAMES MCBRIDE DABBS. 270 pages. Cloth. Knopf. New York. 1958. Price \$4.00.

A Southern intellectual and farmer investigates the desegregation issue, starting with the exclamation, "Like the rest of the South, I am confused." This, by the way, could also be the verdict on the book; it abounds with ambivalence and "middle-of-the-road" contradictions. Although the author has some derogatory things to say about politicians and economic motives propelling Southern fanatics, he never clarifies his position.

Men and Morals. The Story of Ethics. By WOODBRIDGE RILEY. 425 pages including index. Paper. Ungar. New York. 1960. Price \$1.95.

This volume is a reprint of a standard textbook first published 31 years ago on ethical and moral ideas and their history. It is a very useful reference work for any library devoted to social science or to the various sciences dealing with personality. It does not, however, cover some of the more recent developments such as Existentialism, Western interest in Zen Buddhism, or theories deriving from the psychoanalytic school or from Jung.

Strange Relations. By PHILIP JOSE FARMER. 190 pages. Paper. Ballantine. New York. 1960. Price 35 cents.

Philip Farmer is a science fiction writer whose explorations are more in the realm of the fantasied than of the extrapolated future. The present stories concern, among other things, a man who achieves literally (and unpleasantly) something of a physical return to the uterus.

A New Method for Cytological Diagnosis of Pulmonary Cancer.

By LUDWIG VON BERTALANFFY and FELIX D. BERTALANFFY. *Annals of the New York Academy of Sciences*. Vol. 84, Art. 5. Pages 225-238. Paper. Published by the Academy. 1960. Price \$2.00.

This is the application of the acridine-orange fluorescence method for exfoliative cytology in gynecology to the diagnosis of malignancies of the respiratory system.

The Book of the Dead. The Hieroglyphic Transcript of the Papyrus of Ani. Translation and introduction by E. A. WALLIS BUDGE. XIV and 704 pages with index, half-tone plates and numerous vignettes. Cloth. University Books. New York. 1960. Price \$12.50.

The Book of the Dead is the record of the oldest rites of passage known to man. Written for the benefit and the use of the dead, it is a collection of the prayers, the magic and the rituals by which the men and women of ancient Egypt denied the reality of death and mapped a journey in the underworld in which the soul became a god and joined the company of the gods in eternal life.

The text of the present volume derives from a papyrus transcript of a Theban recension prepared for a royal scribe of the XVIII dynasty—around 3,400 years ago by today's generally accepted dating. It contains the original of Ani's scroll, set in hieroglyphic type, with translation and notes by Budge, reproductions of the vignettes which originally illustrated it, and half-tone plates of some of the major, originally colored illustrations. The present printing is, except for the large illustrations, that of the standard Medici Society version of 1913. It contains an introduction covering the history of the book and a discussion of Egyptian religion, and is equally adapted for the use of the student of the Egyptian language or of Egyptian thought.

Like many documents of other dead religions, *The Book of the Dead* is a poignant record of human hopes, fears and futility in the ages-old effort to deny the fact of death. Unlike some other religious documents, this most ancient of them all—its ultimate derivation is prehistoric—has elements of the genius of the race which make it of concern, not only to all educated people, but of particular concern to all involved in the study of the human mind or soul.

Tomorrow Will be Sober. By LINCOLN WILLIAMS. 208 pages. Cloth. Harper. New York. 1960. Price \$3.00.

Lincoln Williams is a psychiatrist who operates a private hospital and clinic for the care of alcoholics. His book is on a nonprofessional level for general distribution. As such, it is an excellent text, describing in simple terms the physiology of alcohol, the causation, symptoms and treatment of alcoholism, and various types of persons who might become addicted.

Certain chapters where Williams describes the personalities and emotional types who might become involved with alcohol, are oversimplified. The reviewer also feels that the author is far too optimistic and that he gives the impression that almost any alcoholic who wishes to be cured can be cured. The problem of alcoholism remains one of the tremendously difficult tasks facing medicine and psychiatry.

The book is worth while as a contribution to the understanding of the problem by those who work in related fields and by persons interested in learning about the modern concepts of alcoholism and its treatment.

Happy Families Are All Alike. By PETER TAYLOR. 305 pages. Cloth. McDowell, Obolensky. New York. 1959. Price \$3.95.

A collection of short stories is allegedly held together by the Tolstoy quotation from *Anna Karenina*, used as a title. Most of the stories concern the bizarre, and the South. One, "A Friend and Protector," is interesting: It deals with a colored man who constantly gets into trouble and is constantly rescued by his white employer: "... in the moment I understood that Jesse's outside activities had been not only his, but ours too. My Uncle Andrew, with his double standard or triple standard—which-ever it was—had most certainly forced Jesse's destruction upon him... But they [uncle and aunt] did it because they were so dissatisfied with the pale unruin of their own lives..."

The Meaning and Methods of Diagnosis in Clinical Psychiatry. By THOMAS LOFTUS. 169 pages. Cloth. Lea and Febiger. Philadelphia. 1960. Price \$5.00.

This book attempts to explain to the resident and general practitioner the methods of the psychiatric examination and the elements of differential diagnosis. Differential diagnosis is shown in tabular form, with the outstanding presenting characteristics featured. There is a chapter on exercises in diagnosis—good for the beginner in psychiatry. The explanation of the psychiatric examination is excellent.

This book covers its purpose, that is, an introduction of the resident or general practitioner to the psychiatric examination, and the differential diagnosis of the various functional mental syndromes.

Man: The Bridge Between Two Worlds. By FRANZ WINKLER, M.D.

268 pages including index. Cloth. Harper. New York. 1960. Price \$5.00.

More than a century ago, William Wordsworth poignantly cried out against materialistic civilization:

"The world is too much with us; late and soon
Getting and Spending, we lay waste our powers
Little we see in Nature that is ours. . ."

This is Dr. Winkler's main theme; and passionately he cajoles, reasons and implores the reader to pause and devote himself to the contemplation of natural phenomena, developing intuitive cognition and inner resources, fulfilling innate spiritual longings. In his 30 years of medical practice, the author has developed this therapeutic approach to the major moral and psychological ills, and to a mode of child rearing which cultivates a wonder and gratitude for life. Summarily rejecting the Freudian theory of sexual conflict, Winkler's creed is a tempered mystical, Jungian approach. He writes with impressive erudition, and launches some stimulating arguments, quoting from classical Greek and ancient Hebrew history, as well as displaying knowledge of modern scientific developments. He attempts, but fails to resolve, the old problem of whether the universe has divine origins or whether scientific explanations suffice. Unfortunately, he wears blinders when it comes to such controversial issues. But the book does make a powerful appeal for the "basic trinity" of Wisdom, Art and Religion, and does convey Winkler's "intangibles" with clarity.

How To Put Up With People (Including Yourself). Avoiding Psychoanalysis. By RICHARD W. LOVELAND. 95 pages. Cloth. Exposition. New York. 1960. Price \$2.50.

Why bother with intensive medical-psychological studies, earning degrees and such nonsense? Any literate barfly can read some Freud and Adler, add a dash of Jung and Overstreet, and a bit of Norman Vincent Peale, and mix it up with some good old common sense to derive a cure-all sure-fire psychotherapy! "The man on the next stool" in this whimsical little book, puts the whole thing in a nutshell. People are all repressed, he concludes. They should recognize their "visceral needs" and basic hostile, aggressive urges. Through his slightly high hero, the author tells everyone they must face these facts, and seek release in fantasy where they can commit murder or rape to their heart's content. (This doesn't hurt anyone and makes you feel better.) Aside from some very basic confusions (such as getting realistic fears mixed up with neurotic anxieties), and aside, also, from working too hard for some humor, the book is a clever little set-up in recording the conversation on psychiatry of two companions with a few under the belt. It doesn't strive for much beyond, and still falls somewhat short because of inept writing.

Six Existentialist Thinkers. By H. J. BLACKHAM. vii and 173 pages. Paper. Harper. New York. 1959. Price \$1.25.

This exposition of the views of the six leading Existentialists (Kierkegaard, Nietzsche, Jaspers, Marcel, Heidegger, Sartre) by an English philosopher originally appeared in 1952. It is earnest, lucid and succinct. The emphasis is more on the philosophical than psychological assumptions and implications of the Existentialist viewpoint. Although written with sympathy for the authors, this little book contains well-taken critical remarks and outlines the differences, as well as the similarities, among the six writers.

Existentialists take the following and other similar propositions seriously and try to grasp their full meaning: What is Being? To comprehend existence one has to go beyond logical thought. There is no lasting nature and essence; there is only existence and history. Existentialism is concerned with reflections on the strivings of individuals, with grappling with one's own individual fate, with the unique relations of the individual to the world around him. Blackham offers a very sound, calm, and clear introduction to Existentialism.

An MMPI Codebook for Counselors. By L. E. DRAKE and E. R. OETTING. 140 pages. Cloth. University of Minnesota Press. Minneapolis. 1959. Price \$3.75.

Here is another contribution to the large and growing literature on the MMPI, undoubtedly the most widely used personality inventory ever published. This book is designed solely for counselors who use the test in their work and find it difficult to interpret the normal profiles which they are likely to obtain from their clients. The MMPI has been so constructed as to permit its easy use in the diagnosing of neurotic and psychotic patients but its use for mildly maladjusted cases has been limited. What the authors have done is to note the kinds of characteristics that subjects with given MMPI scores are likely to have; and the greater part of the book simply consists of a list of MMPI codes and the traits associated with them. The counselor can look at his MMPI scores, refer to the book and note the traits his client probably has. It may, therefore, be a convenient reference source for him.

If such a book is to have value, however, the descriptive traits should be highly meaningful. The reviewer does not think most of those used by the authors, culled from counselor reports, are. For example, associated with one profile pattern for women are these characteristics: socially shy, lacks skills with the opposite sex, lacks self-confidence. One doubts that a long test has to be administered to obtain this sort of information. No doubt the MMPI is a valuable testing instrument but possibly it is not too well suited for use in the ordinary counseling situation.

Life Under The Pharaohs. By LEONARD COTTRELL. 255 pages including index. Cloth. Holt, Rinehart and Winston. New York. 1960. Price \$5.00.

Life Under the Pharaohs is an account of how people lived and of what they thought in a time, place and society very different from our own. The author has taken short extracts of historical and archeological material and has interpolated, for illustration, a fictional account of an upper-class Egyptian family in the time of Tuthmosis III. This is an interesting introductory volume and a contribution to world understanding.

The War. A Concise History 1939-1945. By LOUIS L. SNYDER. 579 pages with index, half-tone illustrations, maps and appendices. Foreword by ERIC SEVEREID. Cloth. Messner. New York. 1960. Price \$7.95.

Professor Snyder is a recognized expert on modern European history. An American, he took his doctor's degree at the University of Frankfurt am Main; he served as an American air corps officer during World War II. His history is a conventional record of crises and activities from the Armistice of November 11, 1918 past the lowering of the iron curtain between World War II victors. It is a scrupulous record of cause and effect, with campaigns, battles, casualties carefully dated and tabulated. It is as objective as could be expected from a patriotic American who has no use for the revisionists who have tried to exculpate the enemy after two world wars. The appendices include a list of recommended reading, a brief "headline history," a list of military code names and a glossary of the major allied conferences of World War II. This book could well have a place in every library, specialized or general.

T. H. Huxley. Scientist, Humanist and Educator. By CYRIL BIBBY. 330 pages including index. Cloth. Horizon. New York. 1960. Price \$5.00.

This is a biography of T. H. Huxley with its emphasis on his roles as a scientist, humanist and educator. Huxley's abilities approached universal genius. Besides his achievements as a scientific upholder of Darwinism, Huxley took part in a campaign which came close to revolutionizing higher education in Great Britain. Huxley was a pioneer in winning academic recognition for science. He was perhaps more responsible than anyone else for the reorganization of the University of London; he served as rector of the University of Aberdeen; he devoted much time to the London school board and he won an honored place in the world of the older universities of England: Oxford and Cambridge. Bibby's biography contains a select list of Huxley's publications, a "conspectus" of his life and times, a long list of references and an excellent index. There are forewords by two of Huxley's grandsons, Aldous and Sir Julian Huxley.

This book should have the attention of everybody interested in scientific education. The American educational world could do with a Huxley today.

The Language of Psychology. By GEORGE MANDLER and WILLIAM KESSEN. 301 pages. Cloth. Wiley. New York. 1959. Price \$6.75.

Two young psychologists, convinced that "an examination of the psychologist's language provides a basis for understanding the status and development of contemporary psychology," have produced a sophisticated account of the vocabulary and grammar (theory construction) of psychology. The book is an impressive achievement because it deals with complex problems of the philosophy of science as applied to psychology in so lucid a manner that the reader who is quite ignorant of the field will find the book not merely comprehensible but genuinely instructive.

Psychiatrists are not noteworthy for the precision with which they use words in their professional communications, and a careful reading of this book should help them become aware of the importance of the semantic structure of a science.

Faiths, Cults and Sects of America. From Atheism to Zen. By RICHARD MATHISON. 384 pages including index. Cloth. Bobbs-Merrill. Indianapolis. 1960. Price \$5.00.

Sound information on the various religious bodies, sects and current philosophies is as useful to the psychiatrist as to any professional person. It has been remarked many times that it is sometimes difficult to distinguish a bizarre personal concept from an unfamiliar "religious" belief. Mathison's book presents accounts of numerous strange sects and some of the smaller recognized denominations of the great American scene. There are notes here on subjects ranging from the House of David to voodoo. The book, however, does not cover the major Catholic and Protestant churches, and it is written with an air of flippancy, whether the subject concerns a religious swindle or a sincerely-held but unusual belief.

Teaching the Mentally Retarded Child. By NATALIE PERRY. ix and 282 pages. Cloth. Columbia University Press. New York. 1960. Price \$6.00.

The writer, a teacher of the mentally retarded for over 20 years, has made a very practical contribution to the field of special education. Parents and teachers will especially appreciate the many concrete suggestions. Programs in self-care, self-expression, music, language, perceptual training, crafts and work activities are described and illustrated on a very practical level.

School administrators, social workers and others interested in this area of education will also find valuable comments on school-community relationships.

Alcohol in Italian Culture. By G. LOLLI, E. SERIANNI, G. M. GOLDER, and P. LUZZATTO-FEGIZ. 131 pages. Cloth. Free Press. Glencoe, Ill. 1959. Price \$4.00.

This volume is from the Yale Center of Alcohol Studies. It singles out Italian attitudes in localities where milk does not enjoy great popularity among adults. The authors find that alcoholism is very low in Italy. They find no connection with the high appreciation of milk in some countries where alcoholism is high. They venture into psychiatric fields in the half-assumption that alcohol is some kind of equivalent of milk. They neglect the complex transmutations and unconscious conflicts involved here.

Individual and Familial Dynamics. JULES H. MASSERMAN, M.D., editor. 218 pages including index. Cloth. Grune & Stratton. New York. 1959. Price \$6.75.

The papers in this book are based on the December 1957 and May 1958 meetings of the Academy of Psychoanalysis. The first part deals with masochism and attempts a re-evaluation of theory and therapy of this clinical phenomenon. The second part explores and expands psychoanalytic theory and practice in regard to familial and social dynamics. The papers are well organized and clearly, if briefly presented. There will be readers, however, who are bound to object to the condensations of such complex topics and feel that much of the individual and familial dynamics are lost because of the mere brevity of the papers.

Tortoise and Turtle. By EVELYN GENDEL with drawings by HILARY KNIGHT. Unpaged. Cardboard. Simon and Schuster. New York. 1960. Price \$2.95.

This is a tale—for four-to-six-year olds and older and older—of a wonderful party that Tortoise and Turtle give for Squirrel and Frog and Hedgehog and the other little animals in the shining summer-land of fantasy. They feast on acorns and fruits and green stuff; they laugh and dance and nap and display old-fashioned courtesy in a quaint, clipped language of childhood that did not derive from Lewis Carroll but that Alice could join in joyously. An early Roosevelt would have called this nature-faking; but it isn't nature; it's art, and delightful childhood art. *Tortoise and Turtle* is life as adults believe the sunnier hours of childhood would have life be; and, as such, those wise in psychiatry can applaud it heartily. It would make a splendid gift for any sufficiently small child, and should find a hearty welcome in the waiting room of any children's specialist. For its drawings, as well as its curious but almost inspired English, it seems, in addition, in danger of becoming a childhood classic.

Psychological and Psychiatric Aspects of Speech and Hearing.

DOMINICK A. BARBARA, M.D., editor. 756 pages including index. Illustrated. Cloth. Thomas. Springfield, Ill. 1960. Price \$19.50.

The thirty articles in this book cover psychological and psychiatric aspects of normal speech and hearing, and the psychopathology and psychotherapy of speech and hearing disorders. There is so much included, however, that is elementary for the experienced worker in this area that this reviewer can recommend this huge volume only to the beginning student. Experienced psychiatrists, social workers and psychologists are sure to find this highly priced book a disappointment.

The Rorschach and the Epileptic Personality. By J. DELAY, P. PICHOT, T. LEMPÉRIÈRE, and J. PERSE. Translated by RITA and ARTHUR L. BENTON. 265 pages including index. Cloth. Logos Press. New York. 1958. Price \$6.00.

This is a highly recommended book for all Rorschach workers. Especially noteworthy is an extensive analytic review of the literature. The authors' approach to the epileptic personality as a bipolar abnormality certainly has clinical significance, and the reporting of their own studies in epilepsy will be of considerable interest and value to all serious workers in this field.

The Lure for Feeling. By MARY A. WYMAN. 192 pages. Cloth. Philosophical Library. New York. 1960. Price \$4.75.

The Lure for Feeling is a study of the philosophy of Alfred North Whitehead and an attempt to relate it to its times by comparisons with Goethe, Emerson, Whitman, Wordsworth and Burrows. It is a perceptive, sympathetic study and relates both the artistic and mathematical components of Whitehead's philosophy. It has numerous injections of poetry and writings of both Whitehead himself and other authors, and is well marked with references.

Like most studies of philosophy, it will probably have a limited reading public.

Blindfold. By LUCILLE FLETCHER. 206 pages. Cloth. Random House. New York. 1960. Price \$2.95.

This is another novel of suspense, by the author of the well-known story, *Sorry, Wrong Number*. It is the tale of an important government scientist, who has become mentally ill, but whose identity and appearance must remain unknown to the doctor who treats him, as security is threatened and horrifying consequences may ensue. The solution lies in the courage and wit of the resourceful doctor. Excellent writing, plausible characters and fine suspense make of this an enthralling story.

Adolescence and Discipline. By RUDOLPH M. WITTENBERG. 318 pages including references. Cloth. Association Press. New York. 1959. Price \$4.95.

This mental hygiene primer is geared for those people with limited specialized training who are helping the teenager through his everyday problems. It is written clearly, almost in a conversational manner, and will be particularly welcome to parents who are seeking information and understanding regarding the adolescent's growth and development of "inner discipline."

The People of Alor. A Social-Psychological Study of an East Indian Island. By CORA DU BOIS. With analyses by ABRAM KARDINER and EMIL OBERHOLZER. 654 pages including index. 81 halftone illustrations, 17 line cuts of children's drawings and photographic reproduction of the Rorschach cards. Cloth. Harvard University Press. Cambridge. 1960. Price \$10.00.

This book is a re-issue of the report of one of the most ambitious and comprehensive studies ever made in the field of social science. Originally published in 1944, it has become a classic and a model for field work and analysis by a collaboration of disciplines in the social and psychological sciences.

The present volume follows the original, with additional commentary in an appendix to the preface and an addition to the introduction to the study, noting how it appears to Dr. Du Bois two decades after it was made. (One extraordinary result came from the naming of Dr. Du Bois' house in Alor, "Hamerika," for America. The villagers, who knew nothing of the United States except from their contact with Dr. Du Bois, were reported to have kept saying during the Japanese occupation in World War II that "Hamerika" would win the war. Five of them were decapitated by the Japanese as a warning to the populace.) Dr. Du Bois feels today that some of the presumed conflict between psychoanalytic and anthropologic theory of culture now seems "a false dichotomy reminiscent of that long and fruitless debate in biology between nature and nurture."

The original volume, reprinted here, covers Dr. Du Bois' field work, and the digestion of her field data by the joint seminar of Abram Kardiner, psychoanalyst and psychiatrist, and Ralph Linton, anthropologist. Dr. Kardiner also contributes analyses of Alorrese culture and individual case histories, and Emil Oberholzer gives a 52-page analysis of the Rorschach records of 37 subjects. Mrs. Trude Schmidel-Waehner gives an analysis of the children's drawings, and the Porteous Maze Test results are analyzed by Dr. Porteous. For the conclusions, the reader should consult the volume itself, which ought to be required reading for social and psychological scientists, particularly for those interested in problems of social re-organization.

Administration of the Public Psychiatric Hospital. GAP Report No. 46. 199 pages. Paper. Group for the Advancement of Psychiatry. New York. 1960. Price \$1.00.

This monograph is designed to outline and answer specific problems in the administration of psychiatric hospitals—for the benefit of the administrator himself and of hospital workers in the lower stages of administration.

The GAP committee, headed by Robert S. Garber, M.D., of the New Jersey Neuro-Psychiatric Institute at Princeton, has done a comprehensive job, covering the general principles of administration and taking up problems of environment, administrative activities and obstacles to good administration. The committee points out that in any hospital an informal communications system tends to parallel the formal one. There is a very good discussion of the use and misuse of this informal system by administrative authorities. This book is to be recommended to all administrators and to other persons exercising responsibility within the hospital administrative system.

The Fiery Furnace. By LAWRENCE WILLIAMS. 217 pages. Cloth. Simon and Schuster. New York. 1960. Price \$3.50.

A first novel deals with a "charming pyromaniac," cured by love. That foolishness is compounded by the fact that the fellow always thinks of an adolescent girl he actually saw, while going through with his pyromaniac actions (one of which crippled his brother). As far this reviewer knows, pyromaniacs' acts provide them with "unexplainable" sexual excitement with accompanying direct sexual images. Otherwise, the author has a smattering of information but uses the latter for the wrong purposes.

From Magic To Science. By CHARLES SINGER. 253 pages including index. Paper. Dover. New York. 1960. Price \$2.00.

The latest of the essays contained in this book was first printed something over 30 years ago. The compilation is a series of discussions by a distinguished medical historian, and it ranges from science in the time of the Roman Empire to the foundation of the medical school of Salerno. The present reprint provides, at a reasonable cost, a book to be valued by anybody interested in medical or general scientific history.

Consciousness and Society. By STUART HUGHES. 433 pages. Cloth. Knopf. New York. 1958. Price \$6.00.

A professor of history at Harvard attempts to trace the "reorientation of European social thought 1890-1930." Sigmund Freud, Benedetto Croce, and Max Weber are the central figures of the study. What the author says about Freud is so lacking in insight and so one-sided, that one can only marvel at the poor results of his extensive reading, leading mostly to eclectic misunderstandings.

The Neutral Spirit. By BERTON ROUECHÉ. 151 pages. Cloth. Little, Brown. Boston. 1960. Price \$3.50.

Chit-chat on alcoholic potables and alcoholism is evidently warmed over from the *New Yorker* and directed to the level of not-very-bright laymen with the memory span of a puppy.

The Riggs Story. By LAWRENCE S. KUBIE. 182 pages. Cloth. Hoeber. New York. 1960. Price \$6.00.

This is an account of the establishment and growth of the Austen Riggs Center (the former Stockbridge Institute for the Study and Treatment of Psychoneuroses). It contains an account of Dr. Riggs' development of his hospital and such items as lists of publications of the staff members and sketches of the grounds.

Penguins Progress 1935-1960. Unpaged. Paper. Penguin Books. Baltimore. 1960. Price 85 cents.

This is an account of the first quarter-century of Penguin Books, an enterprise which has revolutionized publishing in Great Britain and America. The Penguin series has included numerous low-priced works of value for teaching or reference. (*A Dictionary of Psychology* is a Penguin reference book that this reviewer has kept for some years on his desk.) Authors, editors and librarians will find this short account of interest.

Today's Neurotic Family. By HARRY F. TASHMAN. 214 pages. Paper. University Publishers. New York. 1960. Price \$1.65.

Another book for the layman utilizes the first-person-cases-from-my-practice technique and is cast in a frame of ante-bellum psychoanalytic theory. The author's professional experience seems to have been limited to rather narrow urban cultural groups. He recognizes that "the new is not so easily obtainable as the old and is often difficult to conceive, much less to achieve," but he does not go very far beyond this obviously disillusioning experience of every seasoned psychoanalyst to inquire into the next two obvious questions which are, of course: (1) whether persons he does not see have the same experience, without impairing their efficiency, as those he does see; and (2) whether the social significance of even his improved patients can be considered to justify an existence in which time "permits him to take no more than three or four new ones a year." The book is ostensibly written for the purpose of extending this limited utility of the author by imparting his point of view to persons who may gain insight. One has to assume, however, that Tashman knows, not only that those who have no insight are not going to get it from a book (and that those who do have insight which might be improved by a book don't need a book), but that there are few activities more pernicious than do-it-yourself psychoanalysis.

Group Processes. Transactions of the Fifth Conference. BERTRAM

SCHAFFNER, M.D., editor. 196 pages including index. Cloth. Josiah Macy, Jr., Foundation. New York. 1960. Price \$4.50.

This conference took up three subjects: the experimental aspects of pediatrics, the analysis of behavior in terms of central systems, and the cult as a condensed social process.

The subject-matter of the second paper, which attempts to discuss the mechanism of control, is far better handled in the texts on cybernetics in relation to biology, and is certainly better handled by Stanford Beers in his book on cybernetics. The discussions on feedback are argumentative, rather than instructive.

The last paper, although of interest as a curiosity, suffers greatly as an anthropological study from seminar processes rather than becoming enhanced by them. The seminar, described as a method of increased group communication, suffers in some ways because of tangential inclusions and diversions. The author of this last paper describes so-called "cargo cults" occurring in the Pacific islands, a modern transformation of the cult system, but without any real understanding or discussion of the underlying principles of cult-formation.

The reviewer considers this book a poor conference report.

Emotional Maturity. By LEON J. SAUL, M.D. Second edition. 393 pages including index. Cloth. Lippincott. Philadelphia. 1960. Price \$6.50.

The various courses of personal development leading to the ideal state in which one's adaptability is high, regressive tendencies are low and vulnerability is minimal, are herein most clearly and powerfully stated by Dr. Saul. In deliberately nontechnical language, and with more than ample clarifying illustrations and case material, this book further emphasizes the effects of early experiences on adult behavior with possible neurotic manifestations. There are plentiful gems to be found in this book, in the author's handling of concepts such as dependency and hostility, receptivity, etc., and in his whole positive, preventive approach, as well as his strikingly rational observation and treatment methods. One might only question the judgment involved in devoting such a very large segment of this revision of the 1947 volume to the author's World War II experiences, with the sections on battle neuroses, combat fatigue, court martials, etc. Further criticism can be leveled against the tendency to oversimplify, frequently, giving the reader an impression that after one or two sessions of therapy this doctor understands, imparts insight and cures his patients. This book is, nevertheless, recommended highly for its forceful statement and for its extent of comprehension and exposition of the dynamics of emotional maturity and treatment of neurosis.

Essentials of Family Living. By RUTH M. HOEFLIN. 282 pages. Cloth. Wiley. New York. 1960. Price \$5.75.

This book reports the outcome of a course given at the college level for students, and purports to teach the young adult the secrets and mysteries of getting along with his fellow man. It describes what the relationship should be in an ideal family setting, taking up the interrelationships of siblings, of parents, and of children and parents at all stages of life. It has been this reviewer's experience that a description of the ideal does not benefit the individual in arriving at emotional maturity; and in spite of the author's statement that the course benefits people in thus arriving, the reviewer has considerable doubt—since there is no presentation of data.

The book is well-written and interesting as a basis for a course in social psychology at the college level, but will not benefit the individual student in a better understanding of his own emotional problems.

The Rhythm Way to Family Happiness. By JOHN P. MURPHY, M.D. and JOHN D. LAUX. 200 pages. Cloth. Hawthorne. New York. 1960. Price \$3.50.

This book was written as a basis for married couples' understanding of the principles of the rhythm method of preventing conception. Most of the book consists of charts to determine the length of the menstrual cycle and the days on which conception can occur. The book stresses that the rhythm method is based on avoidance of conception rather than the contraception. It answers many of the simple questions concerning the menstrual cycle and fertility and should be of value to any married couple interested in planned conception.

Mental Health Education: A Critique. Issued by Pennsylvania Mental Health, Inc. 180 pages including bibliography. Paper. Philadelphia. 1960. Price \$1.00.

This is a valuable book for anyone interested in mental health. Reporting the conference of the National Assembly on Mental Health Education that was held in 1958 at Cornell University, the volume is divided into two parts. The first section reports the proceedings of the assembly. The second section presents concepts and current practices in mental health education. The papers are provocative and will surely be stimulating to both the professional and the student.

Psychology of Education. By THOMAS C. CAMPANELLE, Ph.D. 278 pages. Cloth. Chilton. Philadelphia. 1960. Price \$5.50.

This is a textbook for introductory psychology courses at the undergraduate level. It consistently reflects Catholic philosophy. The book has limited value.

Perspectives in Psychological Theory: Essays in Honor of Heinz Werner. BERNARD KAPLAN and SEYMOUR WAPNER, editors. 384 pages with index. Cloth. International Universities Press. New York. 1960. Price \$7.50.

Eighteen authors prepared fourteen papers for this testimonial to the scientific and teaching activities of the Clark University professor of psychology, Heinz Werner, whose main contributions have consisted in tracing the phases of mental development from birth on to maturity. As is usually the case with volumes of this kind, the papers have some relation to the main theme, psychological development (intellectual and broader functions of the human species), but make only incidental and rare references to Werner's specific ideas or experimental findings.

The list of contributors is impressive and contains names very well known in the field of psychology and psychopathology, e.g., Kurt Goldstein, Norman Maier, Gardner Murphy, Theodore Schneirla. Most contributors repeat the same or practically the same observations they presented in their earlier publications.

Schneirla's article on "instinctive behavior, motivation, experience and development" is an exception and contains new thoughts, supported by relevant and convincing factual observations and experiments, on the very important and interesting topic of what is innate and how to differentiate it from the effects of experience (including deprivation of chances of active behavior). All contributors cite relevant facts and always interpret them in theoretical terms. Therefore the title, "perspectives in theory," is most appropriate, and the book itself is very instructive in many diverse aspects of human psychology.

The Social Psychology of Groups. By JOHN W. THIBAUT and HAROLD H. KELLEY. 313 pages. Cloth. Wiley. New York. 1959. Price \$7.00.

This is not just another book about groups which details the numerous discrete investigations in this flourishing field. Rather, it presents a theory of group behavior which attempts to integrate, and give order to, some of the common phenomena studied by social psychologists and sociologists. The special virtue of the book, and one that too few possess, is that it enables us to look at old (and not so old) materials in a new way and to see the relatedness of previously isolated data. Clearly, therefore, this book is an important one.

The basic element in the theory is an analysis of the interaction between two persons (or a dyad). The interactions between A and B can be summarized in a matrix, the cells of which indicate the rewards and costs accruing to A and B. From this simple model, Thibaut and Kelley have fashioned a sophisticated and coherent account of important segments of social behavior.

Stuttering: A Symposium. JON EISENSEN, editor. 402 pages including index. Cloth. Harper. New York. 1958. Price \$6.00.

Various concepts of stuttering are presented here by six authorities in this field. Each contributor draws upon his own research and clinical experiences to investigate the nature and cause of the problem and suggest methods of treatment. The book is especially recommended to speech pathologists and students. However, any professional person who is at all interested in this problem will surely want to read it.

No Compromise! By ARNOLD WHITRIDGE, Ph.D. 212 pages including index. Cloth. Farrar, Straus and Cudahy. New York. 1960. Price \$4.00.

Dr. Whitridge writes briefly and vividly of the road to the Civil War, with emphasis on the fanatics of both sides. He depicts the psychopathology of leaders who for 30 years had been working toward conflict. He believes that in 1860 time was running out and that "the South might have peered into the future and seen that slavery was doomed." But he adds, "There are moments in the life of every nation when the people feel that the limit of human endurance has been reached. So it was a hundred years ago."

Education in a Free Society. By HENRY STEELE COMMAGER, ROBERT W. McEWEN and BRAND BLANSHARD. 62 pages. Cloth. University of Pittsburgh Press. 1960. Price \$3.00.

This small book comprises three lectures on aspects of "education in a free society," delivered in 1959 at the University of Pittsburgh by three distinguished educators: Henry Steele Commager, historian; Robert W. McEwen, president of Hamilton College; and Brand Blanshard, professor of philosophy at Yale University.

Commager devotes his attention particularly to the development and the tasks of the urban university, noting its responsibility for the re-building, the enrichment and the beautification of the city. McEwen discusses the "liberating" arts as having the role of providing "the intellectual discipline and insight prerequisite to the solution of the complex problems which specialists must face, the general education needed by intelligent adults in a fast-moving world." Blanshard's definition of the aim of a liberal education is "to produce reasonable minds." He notes that in a country where "Jimmy Hoffa can be an idol, and attacks on *Unesco* make thousands cheer, one can hardly rely on reasonableness as a winning card. But then success in the ordinary sense is not what education is for. The business of education is to show that nothing fails like success if that is achieved with inward emptiness, and that nothing succeeds like failure, if that is purchased by integrity of mind."

The Psychology of Affiliation. Experimental Studies of the Sources of Gregariousness. By STANLEY SCHACTER. 141 pages. Cloth. Stanford University Press. Stanford, Calif. 1959. Price \$3.75.

This is an exceptional book on two counts; first, it records a surprising relationship between ordinal position in the family and affiliative tendency; and, second, the materials are presented in a superbly lucid fashion.

The major contribution of the book, and a totally unexpected one, is Schacter's discovery that, as compared with later-born children, only and first-born children are more prone to anxiety and more likely to attempt to reduce anxiety by seeking out the company of others. Further, this relationship appears to hold for the entire range of ordinal position, so that there is a progressive weakening of the affiliative tendency with increase in ordinal position. The discovery, which originally showed up in some experimental findings, is supported by additional evidence from a variety of other sources.

Schacter recognizes that ordinal position as such is a relatively meaningless variable, but presents evidence that it is related to early dependency, which probably is the major source of affiliative behavior.

This is an important contribution to social psychology and cannot be recommended too highly.

The Ancient Myths. By NORMA LORRE GOODRICH. 256 pages with index. Paper. Mentor Book. New American Library. New York. 1960. Price 50 cents.

The author of *The Ancient Myths* is a schoolteacher, founder of a school in Normandy for European and American children, and a scholar of wide interests. She presents her myths after the manner of Hawthorne, selecting and combining material from various versions into coherent tales, and adapting for her audience. There is too much interpolation and interpretation in some of them for this reviewer's taste, notably in the Cretan tales which culminate in her own version of Theseus and the Minotaur. The temptation to Bowdlerize has been restrained; babies are born out of wedlock, and such incidents as Osiris' fathering of Anubis by Nephtys are included; but there is a subtle aroma of antisepsis nevertheless. The reviewer feels this book is principally of interest to adult readers in its inclusion of material that is hard to find outside of specialty libraries; material from the epic of Gilgamesh and myths from Persia, Afghanistan and India for example. The Norse myths are not included; and, considering their vast importance in our cultural background, this is rather more than a pity.

Leisure in America. By MAX KAPLAN. 350 pages. Cloth. Wiley. New York. 1960. Price \$7.50.

This important book should prove to be of practical value to reflective thinkers in a wide range of activities. Kaplan has brought together much material not easily accessible. Although he has a tendency to be uncritical of what he includes (a flat-dwelling Chicago apartment family's inclusion of seeds and garden tools among current leisure materials is utilized without comment) and of what he accepts (generalities as to Swiss "national traits" are employed without any suggestion of a lack of homogeneity), the reader should not have any particular difficulty in detecting such latitude.

Kaplan's nineteenth chapter, devoted to "Personality and Social Roles in Leisure," appeals particularly to the psychiatrist. It begins with a quotation from R. Havighurst, "The significance of leisure activities is more closely related to personality than to the social variables of age, sex, and social class. Thus leisure activity is an aspect of personality. It is a response to personality needs, being one of the ways by which people express themselves." He continues with a 1950 conclusion by a GAP committee that neither personality nor society are closed systems. "Personality and society are viewed here not as closed systems but as continuously interacting. Each influences the other selectively toward change. While the intactness of personality is reflected in relatively fixed propensities of behavior, it is simultaneously in continuous interaction with, and is influenced by, the environment. Behavior is determined both by stimuli derived from the internal organization of the person and the external organization of the social environment. Constitution sets limits to behavior potentials, but structured behavior is always conditioned by social experience. The development of personality is influenced both by biological makeup at birth and by the process of internalization of elements of the social environment. All behavior, beginning with birth, is bio-psycho-social."

The book is divided into five sections (Data, Methods and Issues of Leisure; Relations and Variables in Leisure; Types and Meanings of Leisure; Processes of Leisure, and Evaluation and Implication of Leisure) each (excepting the last which is a unit) containing a number of provocative chapters.

Kaplan's is not a definitive book, and avoids the obvious issue of whether misuse of our leisure will prove to be our undoing, but it is an important milestone in a field of study which must be cultivated more assiduously.

The Traitor. By ANDRÉ GORZ. 304 pages. Cloth. Simon & Schuster. New York. 1959. Price \$4.50.

This autobiographical book will fascinate those people who are particularly interested in the sort of Existential philosophy that highlights the rejection of practically everything, including identity.

Oscar Wilde. By FRANK HARRIS. 381 pages including index. Paper. Dell. New York. 1960. Price 75 cents.

This is a very welcome reprint of a famous and one-time shocking biography of Oscar Wilde. It has long been out of print. It appears now with a short but equally valuable essay by Bernard Shaw, "My Memories of Oscar Wilde."

Frank Harris believed that Wilde was vastly mistreated and greatly misunderstood. He says, "it must not be thought that Oscar Wilde was punished solely or even chiefly for the evil he wrought. He was punished for his popularity and his pre-eminence, for the superiority of his mind and wit; he was punished by the envy of journalists, and by the malignant pedantry of half-civilized judges." This is an important and revealing book—as revealing in some ways about its author as about its subject. It will be remembered that Harris' own unconventional sex life (heterosexual) was such that his very frank autobiography is still barred from the United States.

James Joyce. By RICHARD ELLMANN. 842 pages. Cloth. Oxford. New York. 1959. Price \$12.50.

Joyce, the man, steps through this monumental volume with utter clarity for the critics, students of literature and professionals in all fields who have ever wondered about the author of *Ulysses* and *Finnegans Wake*. The life of perhaps the most gifted writer of our time is recorded in minute detail in this outstanding, fine biography.

The Big Ward. By JACOB VAN VELDE. 120 pages. Cloth. Simon & Schuster. New York. 1960. Price \$3.00.

This is a short, powerful novel of old age as experienced by an elderly woman in a home for the aged, and viewed by her daughter. The author's careful choice and control of words and sentence structure are impressive and make for scenes which are piercingly effective.

The author is not primarily concerned with the "problem" of old age as such; she seems to be telling of existence. In this respect, reflecting Miss van Velde's orientation, this story from the very first sentence is rugged, bleak, bitter and filled with hopelessness.

Volunteers' Services . . . Modern "Miracle." By BERNICE M. MOORE. 11 pages. Paper. Hogg Foundation for Mental Health. Austin, Texas. 1958. Price 20 cents.

Bernice M. Moore's pamphlet is an interesting statement relative to the need for and purpose of volunteers in hospital services. She summarizes the dividends in volunteer services for hospitals, and points out the many contributions to the hospital and the community made by intelligent volunteers in institutions and agencies.

The Principles of Moral Philosophy. By BEN KIMPEL. 234 pages. Cloth. Philosophical Library. New York. 1960. Price \$3.75.

No tortured mystic, Kimpel puts the stamp of moral approval firmly upon the man who succeeds (on page 211, there is a curious reflection on the widow's mite). Tenable morality for this professor of philosophy at Drew University has two criteria, logical and practical. "The first is internal consistency. The second is effectiveness in clarifying problems in practice" (p. 37). "The very test of the moral worth of principles is their capacity to contribute to practice" (p. 48). The author is to be congratulated upon the production of a book which is almost entirely devoid of the technical obstacles with which many philosophical exegeses bristle. Kimpel is not a good writer (his plantigrade style and logical counterpoint impair ease in reading) but he is a clear one. It is to be regretted that, having reduced his subject to clarity, the result is not more inspiring.

One agrees with Kimpel's insistence that a moral philosophy must be in accord with scientific fact and logical principle, but scientists turn to philosophers for guidance beyond the area of their own competence. If the measure of morality is itself to be scientific fact, the issue of value becomes lost. One can also agree with the author's acceptance of L. S. Feuer's designation of ideals as "anxiety-inducers" (p. 186) without being willing to sell anxiety short. In rejecting Kant's contention that man possesses a will which can be made free of desires and inclinations, the author nods in the direction of the psychoanalyst, and there is also a brief consideration of the sense of guilt according to the Freudian point of view. Kimpel insists on a rejection of Kant's categorical imperative and of Kierkegaard's refusal to regard consequences. Behavior, he tells us, must be related to practical ends but one looks in vain for more than examples (one is to organize a proper program of estate planning, to have one's children vaccinated, to study available insurance programs, to acquaint one's self with the issues involved in the problem of "socialized" medicine) or operational definitions of these. "Moral responsibility is doing all that will contribute to the enrichment of human life" (p. 44). "The moral worth of a principle . . . rests . . . upon the capacity of 'reasonable' men to bring about a type of life worthy of being achieved" (p. 45). Food is said to be "worthy" if it nourishes us (p. 142). One wonders why it is necessary to invoke a value judgment in such a case. Would it not be enough to say, "X is nourishing"? Is it possible that philosophy has nothing more helpful to offer with regard to questions of moral value than to direct us back to the operational definitions of psychology, biology, sociology and psychiatry?

The Black Book. By LAWRENCE DURRELL. 250 pages. Cloth. Dutton. New York. 1960. Price \$4.95.

This brilliantly written novel about sex and tormented lives was originally written in 1936 and is now presented to the American reading public.

Durrell has an axe to grind against England and his resentment, of course, is reflected here.

At times bitter, witty and intentionally shocking, this book will appeal to those who enjoy an exercise in intellectual gymnastics and to those who wonder about Durrell in his earlier years, before he wrote the *Alexandria* quartet.

The Archetypes and the Collective Unconscious. By C. G. JUNG. Coll. Works, Vol. 9, Part I, Bollingen Series XX. Translated by R. F. C. HULL. 462 pages including index. Cloth. Pantheon. New York. 1959. Price \$7.50.

This is the ninth volume devoted to C. G. Jung's writings. The essays contained here were written from 1933 through 1955 and deal with his core concepts of the collective unconscious and the archetypes. The going is rough, and much is difficult to digest; however, this must be considered basic reading for any appreciation of Jungian psychology. The book is handsomely bound and printed, as is usual with the distinguished Bollingen Series.

Basic Psychiatric Concepts in Nursing. By CHARLES K. HOFLING, M.D., and MADELEINE M. LEININGER, R.N., M.S.N. 540 pages. Cloth. Lippincott. Philadelphia. 1960. Price \$6.25.

This book is divided into two sections, the first dealing with the psychiatric approach in general nursing, and the second more particularly with the psychiatric patient. It suffers from the one problem which is general to any text which attempts to encompass too great a field: oversimplification and generalization.

The first section dealing with general nursing is superior. It stresses the whole approach to the patient. Its one defect is the oversimplification of the answers to problems that patients present.

In the chapters on personality development, the Freudian concepts are used, but the mechanisms are rarely explained to any extent, so that the nursing student may find this section quite difficult.

The portion of the book on the neuroses and psychoses could be improved considerably. The oversimplification and generalization leads to such statements as "suicide is one of the leading causes of death." In the section on treatment there is little to show the nurse what stress is placed on each form.

In spite of its shortcomings, however, this book is a worth while attempt to explain the psychiatric concepts in general nursing as well as in psychiatric nursing.

Hall of Death. By NEDRA TYRE. 215 pages. Cloth. Simon and Schuster. New York. 1960. Price \$2.95.

This is a story of murder and mayhem in a girls' reformatory. The author, who is a social worker, has let herself become so wrought up over the injustices to the inmates of this dreary place, that the tale is only moderately suspenseful, and the individual characters simply do not seem plausible.

Impact. By EZRA POUND. 285 pages. Cloth. Regnery. Chicago. 1960. Price \$5.00.

This is a muddy and abusive book. It is a mixture of acuity and obsession with fiscal-economic theory, prejudice based on race, and scorn for all except the Pound-chosen members of his private aristocracy. The book shows the derailing of a superior intellect by emotional irrationalities and is of interest chiefly for that reason.

A History of Science, Technology and Philosophy in the 16th and 17th Centuries. By A. WOLF. Two volumes. xvi, xv and 686 pages, with index and 316 illustrations. Paper. Harper Torchbooks. Harper. New York. 1960. Price \$1.95 for each volume.

Modern medical history neither began nor developed in a vacuum. Modern medicine sprang from medieval roots, animated and fed by the great fountain of the Renaissance. Its development was comparatively late in the great scientific, artistic and cultural advance, of which—as far as science is concerned—a convenient inaugural period might be the career of Copernicus.

Wolf's history, in fact, covers developments from Copernicus through Newton and the great pioneering scientific efforts of the seventeenth century; and he notes that the present volumes are part of a design in which the scientific history of the eighteenth and nineteenth centuries, then of ancient and medieval times, are to follow. The treatment is necessarily topical, and the divisions are not always satisfactory from the specialist's viewpoint. The great advances of Vesalius and Harvey in anatomy and physiology, for instance, are treated for the most part under the general heading of "The Biological Sciences," rather than "Medicine," and other important medical developments appear under "Iatro-chemistry." This is perhaps all to the good, however, in a work designed to present scientific progress in integration, rather than as separate advances of isolated specialities.

Few of us are as well acquainted as we ought to be with the place of our specialty and our science in the general scientific world; and these books are splendidly designed to make up the deficiency. First published in 1950, they are now presented, beautifully printed on good paper, in an attractive format, at a price designed for the student's or the young physician's book budget.

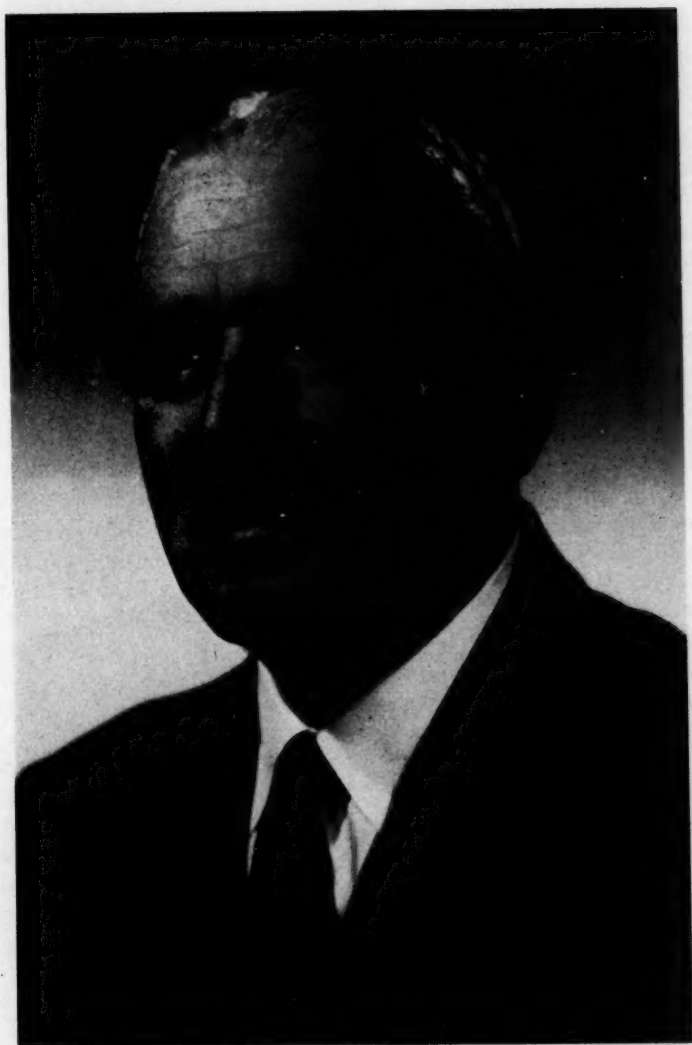
CHARLES E. NILES, M.D.

Dr. Charles E. Niles was appointed to the post of assistant commissioner for administration in the New York State Department of Mental Hygiene on April 21, 1960.

Dr. Niles had been assistant director of Pilgrim State Hospital since September 1952. He entered state service in 1926 as an intern at Hudson River State Hospital.

A native of Rutland, Vt., Dr. Niles received his bachelor of science degree in 1922 and his medical degree in 1925, both from the University of Vermont. He served an internship at Samaritan Hospital, Troy, N. Y. before entering state service. He was in the United States army medical corps in World War II and served in Africa and Italy as commanding officer of a field hospital.

Dr. Niles is a fellow of the American Psychiatric Association, a member of the American Board of Hospital Administrators, and various other professional societies. He has written several scientific papers and articles. He is married to the former Helene L. Wright of Brandon, Vt. His hobbies include fishing, bowling and stamp collecting.



CHARLES E. NILES, M.D.



VINCENT I. BONAFEDE, M.D.

VINCENT I. BONAFEDE, M.D.

Vincent I. Bonafede, M.D., assistant director (administrative) at Craig Colony and Hospital in Sonoma, N. Y. became director of that institution on May 1, 1960. He succeeded George L. Warner, M.D. who retired.

Born in Buffalo, Dr. Bonafede attended the University of Buffalo, receiving his medical degree there in 1930. He interned at the Allied Sisters Hospitals of Buffalo and served a partial residency in the diagnostic clinic at Buffalo City Hospital. He entered state service in 1931 as a medical intern at St. Lawrence State Hospital. He transferred to Craig Colony in 1933 and progressed through successive grades there until his appointment as assistant director (clinical) in 1952 and assistant director (administrative) in 1959. He has done postgraduate work in neuropsychiatry and tuberculosis and has served as a psychiatric examiner at Elmira State Reformatory and for selective service.

Dr. Bonafede is a diplomate in psychiatry of the American Board of Psychiatry and Neurology and the American Board of Mental Hospital Administrators. He is a member of the American Psychiatric Association, the American Epilepsy Society, the American Association on Mental Deficiency, and other professional organizations. He is now secretary of the Seventh District of the New York Medical Society and is a past president and secretary-treasurer of the Medical Society of the County of Livingston. Dr. Bonafede is the author of numerous articles on the neuropsychiatric aspects and treatment of epilepsy.

Dr. Bonafede was married in 1943 to Carolyn Constantine of Mt. Morris, N. Y. He is a member of various fraternal and service organizations, the Elks, Knights of Columbus, and the Rotary Club of Mt. Morris, of which he is now president. He has been active in community affairs. Hobbies include fishing, gardening, photography, spectator sports, and travel.

CONTRIBUTORS TO THIS ISSUE

TOARU ISHIYAMA, Ph.D., Dr. Ishiyama, who is presently director of the department of psychology, Cleveland State Hospital, received his B.A. and Ph.D. degrees from Western Reserve University. In addition to his position as director of the psychology department, Dr. Ishiyama serves as a research psychologist at the hospital. His interests are in the areas of the psychology of organization, social psychology and clinical psychology. He is also a lecturer in psychology at Western Reserve University.

Dr. Ishiyama is a member of several psychological associations and is the author of several scientific psychological papers. He is married and the father of a son.

WILLIAM L. GROVER, M.D. Dr. Grover received his B.A. from Ohio State University in 1940 and his M.D. from the same university in 1944. He also completed a year's work of graduate study in anatomy. After serving in the navy from 1943 to 1946, he returned to Ohio State as a medical resident. From 1950 to 1954, except for a one-year service tour during the Korean War, Dr. Grover worked at Columbus State Hospital, the latter part of this period as chief of medical-surgical services. In 1954 he was appointed superintendent of Cleveland State Hospital, a position which he still holds.

Dr. Grover is a member of national and local psychiatric and medical organizations and has been certified as a mental hospital administrator by the American Psychiatric Association Committee on Certification. He is the author of several scientific psychiatric papers, is married and the father of four children.

KAREL PLANANSKY, M.D. Dr. Planansky obtained his Ph.D. degree in physical anthropology at the Faculty of Science, Charles University, Prague, in 1928. In 1933, he graduated from the medical faculty of the same university. He is presently on the psychiatric staff of the Veterans Administration Hospital, Canandaigua, N. Y., and is clinical instructor in psychiatry at the Rochester University School of Medicine and Dentistry.

ROY JOHNSTON, Ph.D. Dr. Johnston received his B.A. degree in 1952 and his M.A. in 1953 from the University of New Hampshire. He received his Ph.D. from the University of North Carolina in 1957. He is presently a staff psychologist at the Veterans Administration Hospital, Canandaigua, N. Y.

THE STAFF OF THE MENTAL HEALTH RESEARCH UNIT. At the time "A Mental Health Survey of Older People" was conducted, Ernest M. Gruenberg, M.D., Dr.P.H., was head of the mental health research unit, as executive director of the New York State Mental Health Commission; he is now with the Milbank Memorial Fund, New York City. He is also collaborating with Director Robert C. Hunt, M.D., of Hudson River (N.Y.) State Hospital, in evaluating that institution's Dutchess County service.

Joseph J. Downing, M.D., was principal clinical scientist for the survey and was later acting director of the research unit. He is now directing community mental health work at San Mateo, Calif. Harold C. Miles, M.D., M.P.H., who was principal public health physician, is now director of Community Mental Health Services for Monroe County, N. Y. Melvin B. Goodman, M.D., associate public health physician, is director of Community Mental Health Services for Westchester County, N. Y. Bernard M. Kramer, Ph.D., who was senior research scientist in social psychology, is now with the Massachusetts Mental Health Center.

In directing the survey, Dr. Gruenberg functioned as a specialist in both psychiatry and public health. Born in New York City, he attended schools in this country and England before graduating from Swarthmore College in 1937. He was graduated from the Johns Hopkins Medical School in 1941, and he holds the degrees of M.P.H. and Dr.P.H. from Yale. He served internship and residency at St. Elizabeths Hospital, Washington, and Bellevue Hospital, New York City. He was in the army medical corps from 1941 to 1946, in various capacities from battalion medical officer to an assignment in medical intelligence in the surgeon general's office. He has been on the faculties of Yale, Syracuse, Columbia and Harvard. He is a fellow of the American Psychiatric Association and a member of other professional organizations, and has been active in positions relating to aging, mental health research and other aspects of public mental health.

LUDWIG FINK, M.D. Born in Germany in 1901, Dr. Fink obtained his D.D.S. degree at the University of Berlin. He practised as a dental surgeon in Berlin until 1933 when he enrolled in medical school at the University of Turin, Italy. He received his M.D. degree there in 1938. He spent several years in Iran and India until he came to the United States in 1947. That same year he entered New York State service as resident psychiatrist at Syracuse State School, and has been with the Department of Mental Hygiene ever since. In 1953 he transferred to Kings Park State Hospital as a supervising psychiatrist. At present he is in charge of a veterans service there. Dr. Fink is a member of the American Medical Association, American Psychiatric Association, the Association for the Advancement of Psychotherapy, and the American Association on Mental Deficiency.

EDWARD DUNNING, O.T.R. Mr. Dunning was born in Cortland, N. Y. in 1928. He is a Phi Beta Kappa graduate of Colgate University where he received his bachelor of arts degree in 1950, majoring in philosophy and religion. After working three years at the New York State Psychiatric Institute, New York City as an attendant, Mr. Dunning received a New York State Scholarship stipend which led to his certification in occupational therapy from New York University in 1956. At present he is a senior occupational therapist at Kings Park (N.Y.) State Hospital.

GORDON E. RADER, Ph.D. Dr. Rader has been chief psychologist in the Adult Outpatient Psychiatry Clinic of Memorial Hospital, University of North Carolina, since 1957. He had previously been a Veterans Administration trainee in the Hartford Veterans Administration Mental Hygiene Clinic, and research psychologist for the Yale Study Unit in Psychiatry and Law. He also served as staff psychologist at the Institute of Living, Hartford, and at the Veterans Administration Hospital, Roanoke, Va. Dr. Rader received his Ph.D. in psychology from Yale in 1956. He is a member of the American Psychological Association, the Society for Projective Techniques and various regional organizations.

VERA B. FRYLING, M.D. Dr. Fryling is at present completing her psychiatric residency at Mendocino State Hospital, Talmage, Calif. A graduate in medicine of the University of Minnesota in 1953, she served an internship at Abbott Hospital, Minneapolis, and a psychiatric residency at Rochester (Minn.) State Hospital. She also has been a psychiatrist and chief of the continued treatment area at Anoka, Minn., and a staff psychiatrist at Agnews (Calif.) State Hospital.

A. GERALD FRYLING. Mr. Fryling is a candidate for a Ph.D. in political science at the University of Minnesota. He has a bachelor's degree from Oklahoma State College and an M.A. from the University of Minnesota, both in political science. He was an instructor for a time at the University of Minnesota and is now a research assistant at Mendocino State Hospital, Talmage, Calif.

CHRISTIAN ASTRUP, M.D. Born in 1921, Dr. Astrup graduated from the University of Oslo medical school in 1947, and has had his psychiatric training mainly in Oslo. Since 1953 he has been on the staff of the Gaustad Psychiatric Hospital. He has been active in various research projects, notably a large-scale personal follow-up of patients with functional psychoses,

as well as in the field of social psychiatry and psychiatric epidemiology. He studied Pavlovian neurophysiology in Russia and Germany, and has been on a one-year fellowship in the United States, working with Dr. Horsley Gant on conditional reflexes in psychiatry.

ØRNULV ØDEGÅRD, M.D. Born in 1901, Dr. Ødegård graduated from the University of Oslo medical school in 1925. He received his psychiatric training in Oslo, and from 1927 to 1929 at the Henry Phipps Psychiatric Clinic. While serving as an assistant psychiatrist at the Rochester (Minn.) State Hospital in 1930 he collected material for a monograph on the incidence of mental disorders among the Norwegian-born of Minnesota, as compared with the native-born of this state and with native Norwegians. Since then he has published a series of papers in the field which gradually has come to be known as psychiatric epidemiology. He has been medical superintendent of the Gaustad Psychiatric Hospital since 1938, and professor of psychiatry at the University of Oslo since 1945.

E. DAVID WILEY, LL.B. Mr. Wiley is associate attorney and head of the office of counsel of the New York State Department of Mental Hygiene. He is admitted to practice before the New York State and federal courts and is a member of the New York State and Albany County bar associations. He has been in state service since 1936 and with the Department of Mental Hygiene since 1941. Born in Maine, Mr. Wiley was graduated from Albany Law School in 1936. He served for a time in the office of general counsel for the Social Security Agency and was on the Army Air Force Evaluation Board and with the Office of Strategic Services during World War II.

NEWS NOTES

DRS. WARNER AND TRAVIS RETIRE AFTER LONG SERVICE

Dr. John H. Travis, director of Manhattan (N.Y.) State Hospital, and Dr. George L. Warner, director of Craig Colony and Hospital, Sonysa, N. Y., retired on May 1, 1960 after 38 and 37 years of service respectively.

Dr. Travis, a graduate of the medical college of the University of Toronto, worked in hospitals in Massachusetts and at the state hospital in Augusta, Maine, before World War I in which he served for four years in the medical corps of the Canadian Army. He entered the New York State service in 1922 at Buffalo State Hospital and later served as clinical director, first assistant physician and assistant director at Creedmoor. He was superintendent at Willard State School from 1938 to 1941 when he was transferred to Manhattan State Hospital where he remained as institution head for 19 years.

Dr. Warner, born in Ontario, was a student at Queens University Medical School when his studies were interrupted by World War I, during which he served as a medical corps sergeant, as an infantry officer with the Black Watch Battalion and as a navigator with an R. A. F. bomber squadron. He joined the New York State service in 1923 as an intern at Marcy State Hospital. He became clinical director at Matteawan State Hospital in 1931, was named clinical director at Utica State Hospital in 1941, and returned to Marcy in 1943. During his last stay at Marcy he served for eight years as acting director. He became director of Craig Colony and Hospital in 1957.

Both Dr. Travis and Dr. Warner have been author or co-author of numerous scientific papers and articles. Dr. Warner has been succeeded at Craig Colony and Hospital by Dr. Vincent I. Bonafede who has been assistant director, clinical, at that institution. Dr. Nobe E. Stein, assistant director, administrative, of Manhattan State Hospital, is serving as acting director there. A short biographical sketch of Dr. Bonafede appears elsewhere in this issue of THE SUPPLEMENT.

RAYMOND FULLER, SOCIOLOGIST, DIES AT 74

Raymond Garfield Fuller, sociologist and worker for many years for mental hygiene and for the betterment of conditions for children, died at Bar Harbor, Maine, on June 17, 1960. A former resident of New York, he had lived recently at Eaton Center, N. H. Mr. Fuller was a writer, a research worker, an editor and an active member of numerous welfare and mental health organizations, for many of which he did special research.

He was author or co-author of numerous publications, chiefly in the mental hygiene field. He did research for the New York State Department of Mental Hygiene in 1948 and 1949, and he collaborated with Horatio M. Pollock, Ph. D., and Benjamin Malzberg, Ph.D., in the writing of *Hereditary and Environmental Factors in the Causation of Manic-Depressive Psychoses in Dementia Praecox*. He completed a two-year study of state psychiatric services which was published by the National Association for Mental Health in 1955.

MRS. ISRAEL STRAUSS DIES AT 82

Mrs. Hilda Newborg Strauss, widow of Dr. Israel Strauss who founded Hillside Hospital, died in New York City on June 18, 1960. Dr. Strauss founded Hillside Hospital, originally in Hastings-on-Hudson, and now in Glen Oaks, Queens, New York, in 1927, and his wife had been a trustee of the institution for many years.

CONSULTING EDITORS ARE NAMED

The *Journal of Individual Psychology* headed by Professor Heinz L. Ansbacher of the University of Vermont, has named a 10-member staff of consulting editors to assist the editor and the editorial board which is made up of Alexandra Adler, Helene Papanek, Rudolf Dreikurs, Harold H. Mosak and Lydia Sicher. The new consulting editors are: Gordon W. Allport, David Reisman, Robert W. White, Hadley Cantril, Arthur W. Combs, Raymond J. Corsini, Eugene L. Hartley, Abraham H. Maslow, Wilson M. Van Dusen and Adrian L. van Kaam.

LEADER IN SOVIET PSYCHOLOGY DIES

Sergei L. Rubinshtein, a leader in Russian efforts to build up a psychological theory based on Marxism and on the researches of Pavlov, died in Russia on January 11, 1960. He was 70 years old. He had worked extensively during the 1950's on the development of conditioned reflex psychology and in experimentation in the psychology of memory, thinking and speech.

VINELAND SCHOOL PUBLISHES BOOKLET

The Training School at Vineland, N. J. announces the publication of a new 28-page booklet on "Home Care of the Mentally Retarded Child." It was written by members of the Vineland staff, and free copies may be obtained by parents or interested groups by writing to the public relations department of the training school.

"HAND TALKING CHART" STILL AVAILABLE

Hamilton Cameron, M.D., has called this journal's attention to the fact that the "Hand Talking Chart" he devised when he himself was stricken with right hemiplegia and aphasia may still be obtained from him free at 601 West 110th Street, New York 25, N. Y. The chart has been supplied to doctors and nurses throughout the country for the last 12 years; and in 1954 an international research council was chartered to disseminate knowledge about aphasia associated with hemiplegia.

PSYCHOLOGICAL AUTHOR-INDEX ANNOUNCED

A Cumulated Author Index to the Psychological Index, 1894-1935 and Psychological Abstracts, 1927 to date is being published by G. K. Hall & Company of Boston. The 66-year cumulation has been prepared by clipping printed entries from the original author indexes and gathering them into a single alphabet. The clippings are reproduced by offset in book form, are bound in five volumes of about 1,000 pages each, and were to be made available in a limited edition in July 1960.

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THE PSYCHIATRIC QUARTERLY SUPPLEMENT

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1960

Part 1

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